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**University College London**

**PROFESSIONAL PRACTICE ASSIGNMENT  
Submission Form**

**Submitted in part fulfilment of the requirements for the Continuing  
Professional Development Doctorate in Educational Psychology (DEdPsy)**

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**2005**

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## **CONTENTS**

<b>Title</b>	<b>page</b>
The Lovaas Programme	2
The Effects of Bereavement and Loss on Pupils with Severe Learning Difficulties	45
What is the role of the Educational Psychologist in Supporting Children and Young People with Medical Needs?	96
One Size Fits All? Using the 360 Degree Feedback Approach as a Method of Measuring Interpersonal Effectiveness	153

**ASSIGNMENT ONE:  
THE LOVAAS PROGRAMME**

## **THE LOVAAS PROGRAMME**

### **Aims And Scope of the Assignment**

There has been a notable increase in the number of families who make requests to their Local Education Authority (LEA) for interventions that are not ordinarily offered within their local area. One such intervention is the Lovaas Programme, which claims high levels of success for children who have a social communication disorder (SCD).

Following several such requests for the Lovaas programme, Midshire LEA commissioned staff within their Learning Support Service to undertake a preliminary study using a case study approach. This aimed primarily to uncover specific reasons why parents favoured Lovaas over alternative interventions that were offered within the local area.

Evidence from the parents of two children was considered using structured interviews and observations of the pupils. This further enabled researchers to highlight areas for the LEA to consider in terms of enhancing their existing support for young children with SCD. Strengths and weaknesses of choosing Lovaas as an intervention are considered both within the context of the literature and through observational data from the two families. It is acknowledged that this type of small scale study can be helpful in generating suggestions for future research.

## **Practice and Content**

Like many other Local Educational Authorities, Midshire LEA has in recent times, received an increasing number of parental requests to fund the Lovaas programme for their individual children. This programme is a behavioural approach to working with young children who have social communication disorders (SCD) and claims a high success rate in helping pupils develop a range of linguistic and educational skills. (Lovaas 1987). These include the reduction of self-stimulation, increasing compliance, encouraging imagination and play skills.

As a response to several such requests, the head of the 'Pupils, Students and Families' section of Midshire LEA commissioned a small-scale project which aimed to monitor the progress of two particular pupils during a six-month period, using a case study approach. The main focus of the project would be the parental perceptions of their experiences of Lovaas, rather than an evaluation of the approach itself. It was acknowledged that the parents had initiated involvement in the use of the approach, and therefore a key part of the study was to identify reasons their for this choice. It was recognised that there are studies that seek to evaluate the Lovaas approach itself on a much wider scale than would be possible within the constraints of time and the resources available to the LEA.

It was envisaged that the research, although small in scale, might help to elicit factors significant to Midshire parents when considering appropriate support for their child's special educational needs. The information could then be used to evaluate current support systems for parents of children with SCD in the LEA and to introduce new models, if appropriate, to help families to have a greater awareness of the support and approaches within their local area.

#### Proposed Format of the Study

The proposed format of the Midshire study comprised information gained over a period of six months by a research team of individuals working within the LEA. The team was divided in two, with each half working with one of the identified pupils. Information was sought from the children's parents, from professional agencies working with both of the children and from relevant information held in the Educational Psychology Service files. Information was also requested from the school that one of the children attended.

In the planning phase of the study, it was anticipated that the research data would be based upon:

- A structured interview with both sets of parents
- Information from the pupil's Statements of Special Educational Needs and related appendices

- **Monitoring of pupil progress by four, half-termly visits involving structured observations within the natural setting, informal discussion with the parents and video evidence from the session.**
- **Completion of, 'The Autistic Continuum' assessment schedule for both pupils**
- **Recording of pupil attainments against either the, 'Desirable Outcomes' or 'Baseline Assessment' criteria, depending on the age of the identified pupils**
- **A written monthly report from the parents**

**Time for a termly review meeting was also arranged in order for the two research teams to meet to discuss their progress, in terms of both positive factors and constraints. These meetings were held independently of the parents as they were intended to consider the research process, rather than specific results or observations. A consistent approach between the research teams was also encouraged by the discussions that occurred within these meetings and the project co-ordinator attended the sessions in order to establish the progress made in the study.**

### **The research teams**

**The personnel involved in implementing the project were all members of Midshire Learning Support Service, two educational psychologists (EPs), a specialist teacher for pupils with social communication disorders and a senior support teacher. It was planned that each of the educational**

psychologists would work with one of the pupils and that the specialist teacher would work with both of the pupils, alongside the EPs. Each research team would therefore consist of an EP and the same specialist teacher. The senior support teacher acted as project co-ordinator.

### The subjects

Both of the children who participated in the study had a diagnosis of SCD/Autistic Spectrum Disorder and both were engaged in the Lovaas programme. The LEA provided partial funding to the two families involved for the duration of the project, which was financially equivalent to the support that they would have otherwise received within a specialist nursery.

The pupils involved in the study were identified as follows:

Pupil X was aged 5 years 6 months at the start of the study and had moved to Midshire from a London Borough in April 1998. He has a Statement of Special Educational Needs describing him as being, "on the autistic continuum". He lives with his parents and older sister and the family language is English.

Pupil Y was aged 4 years 6 months at the start of the project. His Statement of Special Needs was not finalised during the period of the project due to parental concerns about his placement. He was described in the draft statement as having a 'severe social communication difficulty'. Y lives with his mother and older brother, his parents are separated, but his father is

involved with the daily upbringing of the boys. The family language is English.

### **Objectives of the Study**

The objectives of this study were detailed for the researchers by the project co-ordinator as follows:

- To provide information to the LEA about the nature and structure of the Lovaas programme
- To produce case studies on two Midshire children and to record their responses to the Lovaas Programme in a 'real world' setting.
- To gather the views of each of the two families involved about the attraction of the Lovaas Programme for their child
- To record the research findings in report format for discussion by senior education staff in order to inform the department as to how existing LEA provision can be enhanced to further meet the needs of families within the county.

The extent to which the project succeeded in these tasks is considered further in Section 4 of this document.

### **Implementation of the Study**

#### **Initial meetings**

An initial planning meeting involving the research personnel took place to establish the exact details of which EP would be in which team, dates of the

review meetings and details of how the work would be implemented, in order to promote consistency. The parents of the families were then invited to attend a meeting with all the research personnel. Both parents of each family attended the meeting and the project leader explained the nature of the study and what the involvement would be from both the researchers and the families. Dates for the teams to work with the families were identified.

### **Structured parental interview**

The two educational psychologists devised an interview schedule for the structured parental interview (see Appendix 1). The questions aimed to elicit information from the parents to help understand how the parents first became concerned about their child's development and what happened in the period before and after their child was diagnosed with a SCD. The educational psychologist from the research team who would be involved with the family for the duration of the study conducted the interviews. These were both held on the same day to encourage consistency in the timing of the study.

### **Information from the pupil's SEN Statements, other agencies and EP files**

The children involved in the study were both from families who had approached the LEA for funding for a Lovaas programme and therefore were not chosen to be matched closely as subjects for a study. Information from the EP files and from the appendices of their Statements of Special

**Educational Needs** provided information about the pupils in order to identify what the children's educational needs were, as well as considering how their similarities and differences might affect the study.

### **Family visits**

Four, half-termly visits were made to the family and completion of, 'The Autistic Continuum' assessment schedule (Aaron and Gittens 1992) was planned for the initial and final family visit. It was also anticipated that during these visits, structured observations of the children would take place within the natural setting and that videotaped evidence from the session would be collected.

### **Baseline Assessments**

The staff from X's school were asked to complete a Baseline Assessment at the beginning and end of the study to consider his progress over the time period. A Desired Outcomes assessment was to be completed for pupil Y over the same time period.

### **Parental reports**

The parents in the two families were asked to write a short diary each month to describe their feelings about the progress of the study, changes that they had seen in their children and the Lovaas task that they were currently working on. Other factors, such as the ability to recruit Lovaas staff and family circumstances were also commented upon.

### **Reporting the Findings of the Study**

The final project was to be evaluated and written in report format for a senior education officer, with a view to providing information on the strengths and weaknesses of implementing the Lovaas programme as an intervention, as experienced by both parents and pupils. The authority would then consider why this approach is favoured by parents over local provision and what lessons could be learnt about how to enhance existing facilities, so that parents did not feel the need to look outside the LEA for support. It was also agreed that the parents would receive a written summary of the report after it had been presented to the LEA staff for whom it had been commissioned.

Information collected from the sources stated is considered in section 4 of this paper, as are the recommendations made for the LEA.

## **Psychological Theory and Research**

### **Methods of Research**

The methods used to research this section include the use of electronic databases, the Internet, and consideration of evidence from PEACH (Parents for the Early intervention of Autism in CHildren). The PEACH evidence came from both their website and from information used previously in a tribunal, although not in Midshire LEA. The search terms used in both the 'Psychlit' and 'ERIC' databases included; 'Autis\* young children ', 'Autis\* parent\*', 'Autis\* tribunal', 'Lovaas', 'Lovaas autis\*' and 'Behavioural approach autis\*'. From the Internet, an initial search for, 'Parents Intervention Autism', provided relevant hits that allowed exploration of a number of related websites (such as the PEACH website).

### **Familial or LEA choices of intervention?**

Parents of children who have been diagnosed with a social communication disorder (SCD) now have a wider range of information about available therapies than in previous times. This is mainly due to advances in multimedia information systems such as the Internet. One effect is that there has been an increase in the number of requests made to Local Education Authorities for provision that is not usually available within the local area, or not generally funded by the LEA (Jordan and Jones 1999).

Interest in the Lovaas approach increased in Britain in 1997, after Ivar Lovaas spoke at a London conference arranged by PEACH. Families

naturally wished to seek the support and treatment that they considered to best facilitate their child's developmental progress and the research claims made by Lovaas impressed many families who had children with a diagnosis of a SCD. Parents are increasingly using their legislative rights under the 1993 Education Act to request funding for their preferred intervention method and LEAs have therefore had more parental requests to fund treatments using intensive, structured behavioural approaches, especially the Lovaas programme.

Features of the Lovaas approach include a philosophy of early intervention, intensive direct teaching of educational skills within a distraction free environment and specially trained 'tutors' who work with the individual pupils. Tasks are broken into small stages and successful completion of the separate trials is reinforced by rewards. In reviewing the literature describing a variety of approaches for pupils with social communication disorders, Jordan and Jones (1999) suggested that positive benefits could be gained from those methods which offered early intervention, parental involvement, direct teaching of basic skills and planned integration into mainstream nurseries and schools. Today's Lovaas programme certainly has these features, although this can also be said of other types of intervention. Jordan and Jones concluded however, that there is no real 'evidence base' for the judgements made by Special Needs Tribunals in favouring particular named procedures.

Strong parent information and lobby groups, such as PEACH have supported families by linking them to a Lovaas consultant, supervision team and advisory agency. The estimated cost for this in 1998 was £33 950 for two years. PEACH have also helped parents in requesting funding for the Lovaas Programme from LEA's, (who often have been unwilling to agree to this). Subsequent tribunals enquires have resulted in the judgement that the approach is appropriate in a number of cases (Bibby 1997). Debates within SEN Tribunals tend to promote the parent's favoured approach over that which is offered by the LEA, often by quoting research that indicates a high degree of success for individual children. For example, Cathy Tissot, president of PEACH, stated in the 1998 revision of the parental information pack that Lovaas Approach was, "...the only scientifically proven effective method of helping autistic children." Lovaas suggested in his experimental findings that 47% of the pupils in the experimental group were able to join mainstream classrooms without support, following the intervention. This figure is powerful and compelling, especially when compared with descriptive data from other sources. Bibby (1997) states that although some individuals with autism make a 'virtually full recovery', 50% do not learn to speak, and it is rare for individuals with the disorder to marry or maintain employment. Lord and Rutter (1994) also described their findings that 50% of children with autism fail to develop functional speech. Howlin (1998) reports that out of the population of people diagnosed with autism, 70 to 75 % have learning disabilities, with 50% expected to have severe learning difficulties (described in this case as having an IQ of less than 50).

Critics of the Lovaas study highlight methodological weakness (Jordan and Jones 1999), and problems with the original subject selection, group assignment and validity of the data (Waddington-Jones 1998). Supporters of the approach, some of whom have written letters to be included with the PEACH information to parents include Dr. Mudford from Keele University and Dr. Baron-Cohen from Cambridge University. Dr. Mudford's letter of 3.2.97 contained within the PEACH pack states that parents of children with autism should be offered the Lovaas technique as, "first choice", whilst Dr. Baron-Cohen's letter in the same pack, (dated 23.5.96) supports the wider availability of 'treatments such as this one' (i.e.Lovaas).

### The Work of Ivar Lovaas

Despite a 30 year career in working in applied behaviour analysis, many of the reports of success of the work of Ivar Lovaas derive from the Early Autism Project. This was a single study in which Lovaas suggested that 47% of his experimental group (n=19) had achieved educational and intellectual skills to a level that allowed them to be placed in a mainstream school without support following a 2 to 3 year intervention period (Lovaas 1987). The cohort of pupils in the Early Autism Project was very small and therefore considerable research still needs to be conducted before such generalised claims of success can be made. Lovaas (1993) described children with autism as presenting few behaviours that were 'social or human'. He saw his applied behavioural analysis approach as an

opportunity to: "...build language and other social and intellectual behaviours where none had existed." The description of children having 'few human behaviours' appears to be rather insulting to the individuals with whom he worked. By writing in this way, there appears to be a de-humanising process of the children involved, possibly to make any progress in the experimental group after the intervention appear particularly remarkable. It also suggests that there is a norm of human behaviour that the children were working towards, rather than a range of behaviours that are subject to change, according to personal and environmental contexts.

When Lovaas spoke of the children in the study having no intellectual behaviours, he appears to see children as an 'empty vessel', rather than engineers in their own learning. There is no mention of the SCD masking a subject's ability, or their ability to relate to an individual who is conducting a psychometric test, which is how his researchers looked to assess individual ability.

In the Early Autism Project, subjects in the experimental group received a total of 40 hours of behavioural therapy weekly. Their parents were also trained and involved in the administration of the therapy and pupils were provided with opportunities for integration with peers into mainstream nurseries and schools. These children were then compared with the children in the control group who did not undergo the intensive behavioural therapy. The pupils were not randomly assigned to the control or

experimental groups to reduce bias, rather Lovaas assigned individuals to the experimental group before the control group. Since one reason for non-random assignment was given as 'parent protest', as parents wanted the intervention for their child, (Lovaas 1987) it is likely that those parents requesting placement in the experimental group were especially informed and committed to supporting their children's progress. This being the case, these very committed parents are likely to have been proactive in looking for additional interventions for their child, for example socialising in playgroups or dietary and complementary therapies. Information relating to additional or complementary therapies is not recorded in Lovaas' work.

Other inconsistencies in the research design include the fact that physical aversives (punishments) were used on the experimental group, but not used on the control group because of 'inadequate staffing'. The implication of this statement is that the experimental group had more staff present and therefore the higher ratio of adults to pupils might have affected the experimental results. The fact that different experimental conditions were introduced into the two groups also subjects the study to bias. The use of physical aversives is not used in the Lovaas programme today, and parents should perhaps be aware that there are differences between the current programme and that which in Lovaas recorded a 47% 'cure'.

The measures used to assess pupil performance within Lovaas' study included cognitive tests such as the WISC-R (Wechsler 1974) and the

Stanford-Binet (Thorndike 1972). In the Lovaas paper it is implied that the treatment methods used created an increase in intellectual functioning, as measured on a cognitive test. Debates arise as to the validity of a so-called 'Intelligence Quotient' and whether intelligence can be assigned to a number. It might also be argued that these types of tests are not the most appropriate tools for considering whether a subject had made progress in their 'autistic' behaviours. Terms such as, 'normal intellect' are also not necessarily helpful as it assumes intelligence to be a singular and static 'ability' rather than a complex relationship between a set of skills. 'Intelligence' is also context embedded and subject to cultural biases, therefore it is only possible to say what can be considered 'normal' in a particular and specified cohort. It has also not been made clear in the study whether researchers were blind to the purposes of the study. Bias could have been introduced to the study if researchers were aware of Lovaas' hypothesis.

Lovaas considered 47% of the children in his study to have acquired, "an adequate amount of language, social play and self help behaviours after one year". Waddington-Jones (1998) stated that this equated to 2% of the cohort having 'normal functioning' after the 4000 hours of treatment, 45% were described as 'mildly retarded' and 53% as 'severely retarded'. These figures do not appear to be markedly different to predicted levels of learning difficulties within the population of adults with autism, where 50% would be

predicted to have severe learning difficulties (Howlin 1998). Longer-term outcomes for the children involved should therefore be questioned.

McEachin et al.(1996) conducted a follow up study using many of the subjects in the original cohort from the Early Autism Project when the pupils' mean age was 11.5 years. The results of the study suggested that the gains observed in the original study remained over time and that 8 of the 9 pupils who were perceived as having achieved the highest successes were indistinguishable from peers at their school who had never received a diagnosis of autism. They dispute suggestions that the sample in the experimental group had a higher average IQ than those pupils in the control group (Schopler et al 1989) but highlighted other discrepancies between the experimental and control group. These included the age of the pupils, with the experimental group being older than the control group and the fact that some data was missing from the original study. McEachin et al claim that in their opinion, these discrepancies did not affect the conclusions of their research, however the author suggests that bias could have been introduced by these factors. The older children in the experimental group would have had more time and opportunities for interventions than the younger subjects in the control group. This may have included opportunities for attending nursery or toddler groups, and interaction with siblings. It is not possible to identify what the data related to that was missing from the original study, however the fact that the McEachin study was based on incomplete information may also have been a source of bias.

A current evaluation of Lovaas' research is being undertaken in Brunel University by Howlin and colleagues (Unpublished). This study aims to replicate the Early Autism Project by observing a cohort of children with SCD. Research that has recently started at Southampton University targets the training of LEA staff in ABA approaches to work with a range of pupils within the UK.

One cannot ignore the ethical issues of Lovaas interventions. The children involved undertake an intensive programme of generally 40 hours per week, and the benefits of this are debated. The quality of the child and family is altered for 36 months whilst the Lovaas programme is the primary focus. Parents are convinced that the programme will make a significant difference to their child.

The view of PEACH, that the Lovaas programme is a proven, scientific and effective method of helping autistic children is challenged. The proof that is stated comes from a small study in which the research methods are open to bias and invalidity. From Howlin's 1998 work, pupils following the Lovaas approach appear to make minimal gains on the predicted outcomes for adults with autism. This has not prevented families funding tutors to administer the approach to their children however, the reasoning behind why they are prepared to make financial sacrifices in other areas of their

**lives to do this, was one of the main questions addressed in the Midshire study.**

## **Integration of Theory, Research and Practice**

In considering the Midshire study described within this document, it is important to note that it is of the type that Jordan and Jones (1999) discounted in their review of research into approaches for children with autistic spectrum disorders because: "...no definitive judgements can be based on studies involving such small numbers."

Jordan and Jones predicted that some success might be noted in research of the type documented in this paper, as they described this to be typical of individual case study research. They also stated that consistent and systematic work in the form of an intensive intervention such as the Lovaas programme is likely to produce some beneficial results.

Bell (1993) has argued that in small-scale research of this type, selection of criteria and data are necessary and therefore there is a greater risk of distortion than in a larger study. Generalisation is therefore not possible, although tentative recommendations could be made in terms of areas that needed to be considered further.

The strength of the case study approach, discussed in Bell (1993) is that, "...it allows the researcher to concentrate on a specific instance or situation and to...attempt to identify the various interactive processes at work". It also

allowed the identification of key issues, which warranted further investigation.

The purpose of the case studies in this instance was to consider the feelings of the families involved, rather than just the experiences of the children. Howlin, (1998) argues that if parents received better information about the available resources in their area they would be less likely to look for solutions for their children's needs further a field. This is a key aspect of this study and information was collected from parents as to the quality of information that they were given upon learning that their child had social communication difficulties. As described previously, this information was gained from a variety of sources and it is detailed and discussed hereafter.

#### Structured Interviews (see appendix 1)

Information from the structured interviews suggested the following:

- Both sets of parents had initially contacted their GPs about their concerns for their sons. Both were then transferred to child development clinics in their local areas. This resulted in further referral to the education services and the involvement of the educational psychology service. X's parents were further advised by a specialist advisory teacher whilst a home liaison teacher was allocated to Y's family.
- Both sets of parents were given information about nursery provision but not specific information about how this provision would help to meet the

specific needs of their child (for example, X's parents were told that the TEACCH approach was being used, but not how this was relevant to X)

- Parents first read about the Lovaas programme in the national newspapers and then read further about the approach. X's parents bought a book recommended within the article and adopted their own style of applied behaviour analysis prior to employing Lovaas trained staff to formalise the programme. Y's parents contacted parents who were already involved in working on the programme and then contacted PEACH to put them in contact with relevant personnel to start them on a programme.

- Both parents were attracted to the 1:1 support offered by the approach and felt that their children needed a home based programme prior to mixing with other children. X's parents stated that Lovaas gave them confidence and empowerment to support their son. They also liked the fact that the family involvement was at the heart of the programme.

- Both sets of parents wanted their children to be included in mainstream school and felt Lovaas to be a vehicle that would help them to attain this objective. The parents of X and Y were keen to talk about the early post-diagnosis period of their children. It was commonly felt that soon after diagnosis, the family was overwhelmed by health and educational professionals who made assessments but gave little concrete advice. There seemed to be a lack of immediate action in this assessment phase following the initial visits. The parents felt unclear of the roles of the different professionals and felt unclear of whom to ask advice.

▪ This clearly has implications for personnel involved in working with pre-school families in terms of recognising that families wish to have information about the specific roles and specialisms of the individuals involved in working with their child. A timeline of when events will occur could also be helpful, as would a central co-ordinator of the multidisciplinary teams in order to reduce confusion as to who should be contacted at times of crisis.

Several factors were identified that made the approach attractive to the parents:

- The level of support provided by PEACH and the Lovaas tutors and supervisors.
- The structure of the approach which allowed the parents to feel that they were moving forward in terms of their child's developmental targets
- The hierarchical structure of advisors, for example supervisors and consultants which provided a pseudo-medical feel to the approach that legitimised the procedure in the eyes of the parents.

#### Half Termly Visits and Observations

X was observed twice within school and also in 'real world' settings, a shopping expedition and an outing to the Zoological Museum in Tring, Hertfordshire. Y was observed in the room where he works on his Lovaas tasks in his Father's house. Y spent his weekdays on the Lovaas programme and therefore there were no opportunities for the research team

to observe him in different settings. Over the duration of the project, Y's family became increasingly disillusioned with the Lovaas programme, as his behaviour became more challenging. The relationship between his parents also became more acrimonious and the research team were sensitive to the fact that they should not add to the stress placed upon the family. The team were able to problem solve strategies to modify Y's challenging behaviours with the family, and used their observation time specifically in this way. This work was not in the project design and is therefore not recorded in this document.

Behaviour sampling sheets (see Appendix 2) were used to structure observations of X in the classroom. Four headings were used for four different behaviours to be observed. This focused specifically upon his interactions with others, as this was easy to record accurately, no matter where X was in the classroom. This would not be the case for other autistic spectrum behaviours such as his language and communication skills or the quality of his imaginative play. The headings on the behaviour sample sheets were; 'X contacts adult', 'adult contacts X', 'X contacts peer', 'Peer contacts X'. A 'contact' was classed as an approach by one party to the other with communicative intent. This could be by touching them, making meaningful eye contact or verbally attracting their attention.

The observations of X in school were made four months apart. In between the school visits were an observation on a shopping trip, and the final

observation in Tring Museum. The two non-school visits were made in an informal, diary style and were therefore able to focus on richer details than just social interaction.

The school observations were both made on a Tuesday morning, starting at 9.45am. This was to encourage consistency in terms of the lessons covered, the personnel involved, and how X felt in terms of his tiredness or anxiety levels which were thought to fluctuate within the week. In each observation there was almost the same adult to teacher ratio; four school based adults and two of the research team to twenty-five children on the first occasion and 4+2 to 24 children four months later. Unfortunately, the research team were unaware that on the second observation day, a trainee teacher would be taking the class, as would a supply teacher covering for the class teacher's illness. The person supporting X that day had also swapped to a Tuesday for the first time. The classroom support assistants were employed by X's parents to work on the Lovaas programme with him. They also employed the same people to support X in school, therefore there was consistency between the home and school environments.

During the first observation, out of a sample 20 minute period, X made 16 contacts to an adult. This included him making up to 3 contacts within a single minute of observation, and no more than 4 minutes without contacting an adult. Most (12) contacts were to his support assistant (LSA). In the second observation, X made 15 contacts, including up to 4 in one

minute, mainly to his LSA. This time however he achieved up to 8 minutes of independent work between making an adult contact.

In terms of adult contacts to X, there was an increase from 13 in 20 minutes in the first observation to 25 in the second. This appears to have been primarily due to the different working styles of the personnel involved in the lesson.

During the first observation, peers worked well with X, making 18 contacts with him. In the second observation, the same three peers tried to work with X, but he ignored them. More 'autistic' behaviours were noted in the second trial, although X did show signs that he wanted to be part of the group, for example by making a yelping noise when he was taken out of the class to complete some 1 to 1 activities. In terms of X contacting a peer, this was similar in both of the sessions, 11 contacts the first time and 9 contacts the second. It was interesting to note that all the contacts occurred in a cluster in both occasions, and then X took himself away from the other children.

X seemed very dependent on his LSAs in school, and tended to be only directed by them. During the unstructured visits, and without LSA support, X's behaviour was generally appropriate, and this was to the amazement of his mother. He responded positively when she said that he could not have a toy that he coveted in a shop, and also showed no distress at a school party who were visiting Tring museum. It should be remembered however that the

project looked at how two families chose and implemented the Lovaas programme, rather than the effectiveness of the Lovaas programme on modifying autistic behaviours.

During the project, some positive progress was noted in both children in aspects of their communicative and cognitive skills, although this was not assessed using standardised tests. The children's social skills and behavioural management needs were different in each case however, X was increasingly included within a mainstream school, whereas Y continued to display challenging behaviours. Y's parents eventually discontinued the Lovaas programme and sought placement at a residential school.

#### Written Monthly Parental Reports

X's parents report indicated that they were satisfied with his progress during the project and stated that his ritualistic behaviours were less pronounced in every day life. They felt him to be showing less frustration and stated that he was generalising aspects of his expressive language. His attention span had reportedly increased and they considered that he was learning emotions and 'things that other children learn naturally'. During the 6-month duration of the project, X increased his attendance at his local mainstream school from 16 hours per week to a full time placement.

Y initially responded well to the Lovaas approach, but he was compliant only during the Lovaas sessions. His parents stated that he had increased

his challenging behaviours outside of the sessions and at the end of the 6-month period he was smearing faeces, biting his brother and not sleeping at night; behaviours that had only been seen occasionally before the project started. His parents felt unable to take him out of the house, his mother became depressed and his brother displayed challenging behaviours at school. The family felt that there was little attachment between Y and themselves and sought a residential placement for him.

#### Checklist Comparisons

It was not possible to comment on the differences between progress on the baseline assessment programme because the school had not administered it at the beginning of the term as requested, believing that X would not achieve any recordable scores and feeling that this would be a negative experience for the parents.

The Aarons and Gittens checklist had not been administered on both occasions in the agreed manner. This was attributed to time constraints within the context of working for an LEA.

#### Differences in pupil experience

It was envisaged that comparisons might be made between the two children, but this was not eventually possible for a number of reasons.

1. Lovaas was not the sole intervention administered for either pupil:

X was engaged in an increasing amount of time in a school curriculum with programmes managed by his class teacher.

Y had a restricted diet and took homeopathic remedies. He also received medication and his teachers used PECS (Picture exchange communication system). Y was able to use his communication board to indicate his desire for certain food and leisure items.

2. The pupils' pre-Lovaas experiences had been very different.

X attended a playgroup for 3 mornings per week and then an under 5's centre, prior to his move to Midshire. His mother considered his progress in both of these environments to be limited. After reading an article about the Lovaas approach in the paper, X's mother then implemented her own interpretation of the approach by reading instructions from a manual. A Lovaas supervisor was then employed in January 1998.

Y had attended a special needs playgroup before embarking on the Lovaas programme.

3. Both families adopted different approaches to the Lovaas Programme

After the family moved to Midshire, X continued with the Lovaas programme and also attended a local playgroup for 2 afternoons a week. He moved to the nursery of his local school before transferring to the reception class for

16 hours per week. This integration was planned within the Lovaas approach and X was supported in school at all times by one of his Lovaas tutors. X's parents chose to adopt a flexible approach to managing his needs and this included having breaks from the Lovaas programme for holidays. His involvement with Lovaas is flexible, depending upon the weekly demands of the school curriculum. His family was readily able to recruit and maintain their team of tutors from their village and church community.

Lovaas was delivered to Y in a special room within his father's house for 36 hours per week, without regular breaks for holidays. The family had great difficulty in recruiting and keeping their team of tutors, who were coordinated by Y's mother. Further involvement came from a consultant who met with the team every three months and a supervisor who visited fortnightly.

4. The research team were aware that the subjects chosen were not matched appropriately in terms of age.

5. The pupils did not begin the Lovaas programme at the same time as X's parents had been following Lovaas for 10 months, while Y's parents were involved with the programme for 8 months

Despite these discrepancies, the research teams made tentative conclusions and hypotheses about the areas that should be investigated further. It was important to state however that the purpose of the study was not to evaluate the Lovaas programme, rather to consider how two children within the Authority worked on the programme and the implications that this held for the family. Some strengths, weaknesses, and issues for the LEA are considered hereafter.

### **Strengths of the programme**

The Lovaas programme provides a reassuring support system for parents and builds confidence by giving direct advice about how to interact with a child. There is an emphasis upon basic skills training in preparation for nursery which parents view as a logical step to promote their child's inclusion into the mainstream environment. The approach provides opportunities for links with schools who will be supportive to including pupils with social communication disorders. The support of the tutors provides a point of reference to the children that reduces their anxiety levels and helps them to see the sense of their situations. Training is provided for support staff who are used in implementing the programme at home and also for classroom based support in schools. Control is transferred back to the parents thereby generating positive feelings of empowerment.

### **Identified weaknesses**

Parents found it difficult to recruit and maintain staff, especially in rural areas. This had the further implication of training; although the initial team were trained by Lovaas staff, the parents had to train the members of staff who were appointed at later times. This is likely to have diluted the effects of the programme. The cost of tutors began to rise as a result of supply and demand and there was some discussion that this might be connected with a national project based at a nearby university.

Extra burdens were placed on the parents when it was necessary for them to co-ordinate a team of adults as well as working with their child. It was also noted that where the programme was rigidly adhered to family life was suffering because parents had to plan family activities and time with siblings around their commitments to the Lovaas programme. Where the programme did not succeed, the parents were left with an added emotional burden of guilt and failure. The time commitment involved was just too much for some families to work with, 40 hours being recommended by PEACH.

The researchers noted that the approach did not challenge the social communication disorder itself, for example stereotypical behaviours were resorted to in unstructured situations. The programme was also adult directed, and therefore it did not build upon the child's natural strengths and masked the child's personality. The work had an individual focus, rather

than promoting any small group work and therefore encouraging socialisation.

### **Discussion for the LEA**

A perceived advantage for parents of a planned intervention is that it should be prompt and not contingent on a Statement of Special Educational Needs. It would be advantageous for the LEA to have a clear policy and procedures regarding the support available for pre-school children with a social communication disorder, and for this to be communicated effectively to parents.

It would be advisable for the LEA to investigate a range of interventions for pre-school children with a social communication disorder. The researchers also felt it important that any programme should aim to prepare the young pupil for integration into nursery school with their 'mainstream' peers.

Criteria should be established for home based support, with that support monitored and evaluated by relevant LEA support services.

Certain training implications were noted:

- Nurseries and schools should be empowered to receive and support children with social communication disorders
- Home nursery liaison teachers and Portage workers could be trained to support families who have a child with a social communication disorder

▪ Where a pupil is following a home training programme, a member of staff from their local nursery should be trained in the appropriate techniques to maintain progress in the particular mode of working.

The following questions were raised for the LEA to consider further:

1. What further methods of support could be offered to parents, for example telephone helplines, a website, or a parents support group?
2. How can children best be taught basic skills prior to nursery entry?
3. Does the LEA actively promote parenting skills?
4. How to education link to other services, such as the Health Service and Social Services.
5. Whose role is it – and should it be – to co-ordinate these services?
6. Should the LEA favour one approach or a whole range?

Follow-up procedures were not built in to the structure of the research project to consider the way in which the LEA has addressed these questions, although this is an important issue to be raised in future research projects. The research teams considered that they had fulfilled the objectives of the study in terms of providing information to the authority about the Lovaas programme, completing the case studies, gathering the views of the families involved and reporting the findings to senior LEA staff. The project itself however was costly in terms of EP and specialist teacher time, an alternative use of this time would have been for some of the team

members to conduct an extensive literature review. Case studies however do have face validity to non-researchers and possibly legitimise the information gained in a local context for some parents and LEA staff.

The research teams felt privileged to have had the opportunity to work so closely with family, in a way that does not happen often within the constraints of working for a local authority. This provided the chance to understand more fully the emotions experienced by the family with a child who has a social communication disorder. This is not only a sense of loss for the child that they wanted and expected to have, but also a loss of their dreams and ambitions for the child's future. It is perhaps no wonder that families experiencing the bewilderment and anger that follows such a loss, hang on to small shreds of hope and 'miracle cures' that they read of in the press. Perhaps it is the case that whatever the LEA offer in support of the individual child, parents will still look elsewhere to ensure that they felt that they are working as hard as they possibly could to meet their child's individual needs. This being the case, there will always be a new approach or programme that will appeal to the families of children with special educational needs and undoubtedly there will be tribunals to follow.

## **Concluding Comments**

The study recorded in this document aimed to uncover the reasons why more parents are requesting funding for specific approaches for their children, such as the Lovaas programme.

The author considers that the conclusions drawn from this study are restricted by the sample size, the imposed methodology and inconsistencies in delivery between the research teams. Despite the fact that the research is certainly guilty of methodological irregularities and weaknesses, the study was helpful in terms of raising awareness of the issues surrounding parental choices of intervention. Much of the literature indicates that no one approach can be considered the 'most effective' in working with children with SCD's. Fenske et al (1985) concluded that the age of the child at programme entry strongly relates to the positive treatment and outcome for them, with early interventions proving more successful. Following the study, it is possible to make suggestions as to why parents feel the need to look outside the LEA for a suitable intervention for their child. It is suggested that during the period of time in which parents are coming to terms with a recent diagnosis of SCD for their child, the professionals who originally assessed their child and contributed to the diagnosis do not support them.

Parents naturally want the intervention that is going to make the most positive impact on the child's quality of life and it is suggested that new trends will always be attractive to these vulnerable families. It is essential that approaches to autism are researched methodically and scientifically, and that evidence from such studies is made transparent to parents. Perhaps this will then help parents to feel positive about support in their local area rather than looking elsewhere. Local Authorities also have a responsibility to make their services attractive and easily accessible to parents, particularly at times when parents are feeling isolated and do not know where to go to ask for advice. By understanding that they have access to high quality support in their local area, parents will feel more confident, and will be less likely to turn to believing the claims made in miracle cures.

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## Appendix 1: Parental Interview

<b>When did you first become aware of your child's autistic behaviours?</b>	
<b>Who did you consult about your child's difficulties?</b>	
<b>What has been their involvement?</b>	
<b>What information were you given about LEA provision for children with autism?</b>	
<b>How did you learn about the Lovaas technique?</b>	
<b>Were you aware of, or have you tried any other approaches?</b>	
<b>What was it about the Lovaas programme that interested you?</b>	
<b>How long have you been involved with a Lovaas programme?</b>	
<b>How have you established your programme?</b> <ul style="list-style-type: none"> <li>▪ Recruitment of staff/helpers?</li> <li>▪ Baseline assessment at beginning of programme?</li> <li>▪ Number of hours on programme?</li> <li>▪ Any breaks from programme?</li> </ul>	
<b>What progress has been noted?</b>	
<b>Parents' observations of current behaviour/sociability (using Aarons and Gittens checklist)</b>	
<b>Parents' observations of child's functioning in attention control, sensory functioning, concept formation and communication skills</b>	

**Appendix 2: Behaviour Sampling Proforma**

**Name:**                      **No. of pupils/adults in class**

**Time of sample:**

**(contextual notes to be made overleaf)**

<b>Minutes</b>	<b>X contacts adult</b>	<b>Adult contacts X</b>	<b>X contacts peer</b>	<b>Peer contacts X</b>
<b>1</b>				
<b>2</b>				
<b>3</b>				
<b>4</b>				
<b>5</b>				
<b>6</b>				
<b>7</b>				
<b>8</b>				
<b>9</b>				
<b>10</b>				

**ASSIGNMENT TWO:**

**THE EFFECTS OF BEREAVEMENT AND LOSS ON  
PUPILS WITH SEVERE LEARNING DIFFICULTIES**

## **THE EFFECTS OF BEREAVEMENT AND LOSS ON PUPILS WITH SEVERE LEARNING DIFFICULTIES**

### **Aims and Scope of the Assignment**

In recent years, there has been increased awareness amongst professionals as to how bereavement and loss might affect children and young people. Research indicates that children follow a grieving process that is similar to that of adults and also that children conceptualise death in distinct ways at certain ages. Despite the heightened awareness surrounding these issues however, it is suggested that staff in schools continue to find it difficult to talk to pupils within their classes about bereavement and loss. Unfortunately, some staff are then forced to confront these issues following a death of somebody from within the school community, at a time when the adults may be experiencing similar and complex emotions to the children or young people in school.

This was the situation faced by staff working in a special school for pupils with severe learning difficulties (SLD), when one of the pupils died. Following this loss, staff expressed concern that they felt ill equipped to respond to the situation. In particular, they felt that they might make things worse for the children within their care by omitting to provide the opportunities for pupils to grieve, or by missing the signs that a pupil was affected by the loss of their peer. This was not the first pupil death within the school, as the school population contained several pupils with degenerative

or life threatening conditions. In addition, some of the pupils had experienced significant losses or bereavement at home.

The concerns of the staff were discussed with their link educational psychologist, and it was therefore agreed with the school that this area would be explored further in order to support young people within the school community who had experienced bereavement or loss. The staff involved with the initiative would then look to develop a school policy on dealing with loss and bereavement in school, in order to promote consistency and a whole school approach towards pupils in this situation.

The feelings of anxiety that the school staff experienced were not unique to teachers in special schools, but the staff felt that little information was available for them at this time relating to the specific need of pupils with severe learning difficulties following a bereavement. The teachers wanted to know not only how to approach their pupils in talking about death, but also how they might share information and strategies with colleagues and parents about how death and the grieving process might affect children with complex needs. It was discovered through subsequently seeking information on this topic, that this is a much under-researched area and therefore one that requires further consideration.

## **Practice and Content**

Following the death of a young person at a special school for pupils with severe learning difficulties, staff expressed concern to their link educational psychologist that they felt poorly equipped to respond effectively to this sad situation. Several pupils at the school had experienced significant bereavements and other losses within their family life and staff wished to develop their knowledge and skills in this area in order to support children and young people through the grieving process.

### **Developing a working party**

It was agreed that a working party would be formed in order to consider these issues further and invitations were sent to a range of professionals who had an interest in this area. There was a positive response to the invitations and the established working party comprised two educational psychologists, two teachers from the special school who had initiated the original concern, a counsellor from the Brent Bereavement Project and a social worker specialising in learning disabilities

It was agreed at the initial meeting that the group would work together for three months and the five objectives for the group were agreed as follows:

1. To consider areas of bereavement and loss that are relevant to children with severe and complex learning difficulties
2. To develop a theoretical knowledge base about the effects of bereavement and loss within this cohort of pupils

3. To elicit practical ideas and strategies for school staff after experiencing a death in the school
4. To develop an information leaflet for teachers and school staff
5. To provide guidance for policy writing in order that all staff members were aware of school based procedures for responding to the death of a member of the school community.

Subgroups from within the working party were organised for individuals to consider each of the objectives and future meetings were planned to a suggested time scale to complete specific tasks.

#### Meeting the objectives

▪ Objective One: Areas of bereavement and loss that are relevant to children with severe and complex learning difficulties

The group used a brainstorming session to elicit the different 'loss' situations that children and young people might experience. This included loss through the death of a parent or close relative, losses caused by divorce, or parental imprisonment, and complex losses, such as a child from an asylum seeking family might experience. Within this session, many possible loss situations were recorded and it became clear that it would not be possible to research and record all areas relating to children's experiences of loss effectively within the time available to the working party. It was therefore decided that the group would focus specifically upon the

effects of bereavement on children with severe learning difficulties within a school context, although it was felt that the general principles and guidelines that were recorded within the guidance sheet could also be generalised to other contexts.

▪ **Objective Two: To develop a theoretical knowledge base of the effects of bereavement and loss within this cohort of pupils**

Following the first meeting, letters were sent to a range of organisations to request copies of any information that they had found useful in talking to children about death. The organisations included other special schools and charitable organisations including SANDS (Stillbirth and Neonatal Death Society), cancer charities and the Terence Higgins Trust. This information was gathered from the CAF (Contact a Family) Directory, and elicited a 50% response from those contacted. Although there seemed to be a growing number of resources for children and young people who had been bereaved, none of them were specifically targeted towards individuals with severe or complex learning difficulties. The National Autistic Society however had produced a detailed document directed towards professionals working with children on the autistic continuum who had experienced a loss or bereavement.

Library searches also yielded little information on this subject. The areas of 'bereavement in children' and 'pupils with severe learning difficulties' were

therefore initially considered separately within the literature and the concepts were linked together to develop a knowledge base of this area. The expertise within the group was invaluable in integrating the information from the literature with personal experience of pupils who had been in this situation.

A visit to the Brent Bereavement Project was also helpful both in terms of considering their available resources and literature, and the approach that they have adopted to working with young bereaved individuals. Staff at the project reinforced the view of the working party, that there was little information available relating to the effects of bereavement on pupils with severe learning difficulties.

▪ Objective Three: To elicit practical ideas and strategies for school staff after experiencing a death in the school

This was a difficult area to consider because most bereavement literature focuses upon children who are considered to fall within the 'normal' range of development. Information relating to children's understanding of death was all based upon age related norms, without accounting for children's individual differences, as was the information provided to help parents and professionals in supporting a bereaved child. From reviewing the literature, a staged model of children and young people's understanding of the concept of death was produced by the working party that was not reliant

upon individual's ages (See Appendix 1). This was helpful in terms of helping to elicit the strategies that might then be used to support children at different developmental stages in dealing with a significant bereavement.

▪ **Objective Four: To develop an information leaflet for teachers and school staff**

From the information that had been acquired in working upon the first three objectives and from expertise within the group, information was brainstormed and recorded under the following headings. It was considered that this would be important information to include within the leaflet for teachers:

1. Theoretical and research information relevant to this area
2. Types of loss that children may experience
3. Consequences of a bereavement for a child
4. How a child may react to a significant loss or bereavement
5. Questions that the child may have
6. Issues for school staff, including policy decisions

This task highlighted the areas that required further work within the group and research that was necessary on a wider scale. Individuals within the working party collated their knowledge in the production of this leaflet.

The guidance leaflet was distributed within the Educational Psychology Service for feedback and the suggestions for adaptations and amendments were considered and incorporated, as deemed appropriate within the group. After the leaflet had been finalised, members of the working party gave a short presentation to staff at the special school that related both to the subject matter and more specifically about the rationale behind and findings of the working party. The response to the leaflet was not formally evaluated as it was felt to be a small-scale piece of work that was for the benefit of a specific school. It is suggested however that the leaflet could be extended and adapted for a wider audience, including parents of children with SLD.

A request for appropriate resources to be developed in this area for pupils with learning difficulties was made at the staff meeting as was the need for more research into the life experiences of children with SLD. This view was supported by members of the working party.

▪ **Objective Five: To provide guidance for policy writing**

The purpose of developing guidance for policy writing was to ensure that that all staff members were aware of school based procedures for responding to the death of a member of the school community. The working party felt strongly that the policy should be written by the school staff, rather than as part of the project, so that school staff would have ownership of and responsibility for the document.

In working on this objective, information was sought from the literature in terms of curriculum-based approaches for helping pupils understand issues surrounding loss and bereavement that could be used in PSHE lessons. In addition to this, it was felt that staff should develop a clearly written plan that could be referred to in the event of the death of a pupil or teacher. It was anticipated that this should incorporate both short-term actions and longer-term strategies in helping talk to the pupils about what had happened.

A policy guidance 'fact sheet' was developed and presented to staff during the staff meeting. A member of the management team then took responsibility for developing this into a school policy.

### Reflecting on the task

The working party adhered closely to the three-month time scale that had been agreed at the initial meeting and it was felt that the objectives had been achieved, as far as was possible within such a limited period.

The main challenge for the group had been the lack of specific information about this subject, which had not been anticipated. This meant that the task of the working party, rather than being one of gathering and reporting information, had to be much more reflective and intuitive. Much of the information that was gained was based on sharing individuals' personal knowledge and experience of loss, bereavement and working with children

within a wide spectrum of needs. This knowledge and information was then placed within a theoretic framework from reviewing the available literature.

## **Psychological Theory and Research**

### **Methods used to survey the literature**

In seeking information on the subject of Bereavement and Loss in Children with Severe Learning Difficulties, searches were made on the Internet and through specialist psychology library databases. Key phrases used within the searches initially included; "learning difficulties/disabilities and loss", "learning difficulties/disabilities and bereavement", "children and loss/bereavement" and "children and learning difficulties". The latter two searches provided a number of 'hits', but there was very little information in relation to children with severe learning difficulties and their experiences of loss and bereavement. Searches were then extended to consider, "Death/loss in schools" and "critical incidents in schools", but this information also focused on pupils who do not have special educational needs. Information was sought from a range of organisations from the private and voluntary sector whom it was felt might have experience in this area, including specialist counselling services who described themselves as working closely with children who have SLD. Staff working within this context explained that they had also found been little research in this area.

Information was available that described children's experiences of bereavement and loss relating to those pupils who might be considered as being within the 'normal' range of development. Some information was also elicited in relation to children with severe learning difficulties, but there was little information detailing the specific subject matter required. Case study

evidence was available from some sources (Oswin 1991), but the working party felt that this information could be rather idiosyncratic and subject to bias. The members of the working party therefore used information that was available from the literature and combined this knowledge with personal experience in working with children who have severe learning difficulties to develop the information leaflet for schools. The effects of bereavement and loss on children and young people with severe learning difficulties is therefore one area that needs to be researched in order to support this group of young people.

#### **How have pupils with SLD been viewed historically?**

Until comparatively recently, children and adults with severe learning difficulties were viewed as having different needs to their peers without learning difficulties. Marriage and sexual relationships in adults with SLD were thought to be at best inappropriate and were prevented, and efforts were made to 'protect' people with SLD from the harsh realities of society. Education was not thought to be appropriate for this group of individuals, who were often hospitalised or cared for in institutions. Individuals had little or no control as to what happened to them and their wants and needs were not generally listened to or acted upon. Tomlinson (1982) describes how in the period 1890 to 1920, individuals with special educational needs were labelled as being 'feeble minded' or 'morally defective'. She argues that institutionalisation occurred largely because society perceived people with SEN as being associated with criminal activity and immorality. This was

also a time when the Eugenics movement was increasing in popularity amongst certain groups within society. Their philosophy was that society should be improved through selective breeding and that individuals viewed as having differences from the 'normal' population should not be allowed to have children. This view is not held universally however, Cole (1990) describes how there were differing opinions relating to the integration of individuals with SEN into society at the turn of the 20<sup>th</sup> century. This ranged from the belief that people leaving special schools should be segregated from society to a more integrationist approach. Therefore there are some discrepancies in today's understanding in how people with learning difficulties have been perceived and treated in society.

Following the 1944 Education Act, children with SEN were entitled to a different range of experiences. This included a curriculum that would provide individuals with a range of skills, including preparation for life in society after leaving school. Educational categorisation was widespread and individuals were generally segregated to be taught with other people who were described under the same category of need as themselves. It was not until the 1970 Education (Handicapped Children) Act and the 1981 Education Act that the categories were revised to those used today and that education became the focus for all children. There is still however, much re-education of society required as well as support for professionals working in schools to encourage inclusion for all.

Educational Psychology encourages those working within the field of education to understand the evidence behind their practice, but for children in schools today, the curriculum tends to focus upon teaching specific skills rather than looking at the awareness of feelings and behaviours that might be needed in the future. Psychology is beginning to address this imbalance however with research into emotional literacy and through specific initiatives, such as 'Healthy Schools'. There are significant gaps however in the psychological knowledge and theory of many aspects of childhood experience. The effects of bereavement and loss on pupils with severe complex learning difficulties is just one example of a research vacuum and possibly this reflects the lower status with which people with learning difficulties continue to be regarded within today's society.

### Why consider this area?

Morgan (1985) described the role of professionals in schools as preparing young people for life and argued that the subject of death should be part of the curriculum as part of this preparation. This perhaps might be considered to be too narrow a subject focus to spend time on in today's busy classroom, but by providing all pupils with strategies for coping with loss, there would be a significant impact that could extend to other aspects of life in school including pupils' learning and behaviours. The Author therefore considers that a curriculum that provides pupils and their teachers with a common language of emotion is of utmost importance to the curriculum.

### Types of loss that may be experienced

Any child may experience loss through changes in routine, changing their teacher at the end of the school year, moving house, having a friend move to another area, the death of a family member or pet, or occasionally losing some aspect of bodily or cognitive function, such as losing a limb or losing the ability to speak. Morgan (1985) reviewed the literature and was discouraged by the lack of research that had been completed with children on the different losses that they might experience. Within the last twenty years however there appears to have been an increase in considering children's experiences of this type and in current searches, a range of discursive literature has been written on this subject. Research studies are still limited, perhaps due to the sensitive nature of the subject and due to the ethical issues involved in working with children who have had these particular experiences.

Brown (1999) is one author who follows the discursive style and he distinguishes between losses that are 'necessary' to human development and, 'circumstantial' losses that not everybody goes through. An example of a necessary loss is weaning, whereas circumstantial losses include the death of a significant person or a family breakdown. Within the information about children who experience loss, searches yielded very little information about the issues that particularly relate to children with complex needs, many of whom would be placed within a special school environment. It can be argued that children placed within special schools have often

experienced greater losses than same-age peers in mainstream schools have. Pupils with emotional and behavioural difficulties who are placed in special schools will have almost certainly have experienced exclusions from school which disrupt the relationship between the pupil, their peers, teachers and curriculum. The move to any special provision is likely to take the child away from their immediate family community, which can result in the loss of friendships and relationships. Some pupils will be in the care of social services and will have had changes of foster family and some children will have received respite care, particularly those young people who have complex needs where their families may feel the need for a break from caring for their child. All of these circumstances may elicit feelings of loss within a young person, which, as will be explored later, may give rise to a range of complex feelings and behaviours.

With increased levels of family breakdown, children and young people may be experiencing loss of contact with a parent and a change of circumstances when parents form new relationships and perhaps new siblings are born. Other potential circumstantial losses may be a result of abuse, serious illness or an accident. These may be particularly difficult for a child with complex needs to understand if they do not have the language skills for formulating or voicing questions relating to their feelings. Many parents may feel a sense of loss at having had a child with severe learning difficulties and have to come to terms with the fact that they might lose the opportunity for future independence from them. Children with special

educational needs might experience a loss of their status within society, for example by being teased by same age 'mainstream' pupils.

### What does the literature tell us about how pupils respond to loss?

Given the fact that there are lots of opportunities for children to experience such losses, it may appear surprising that so little information is known about their responses to loss situations. There may be a range of motives for this, including the feelings of wanting to protect children from difficult emotions, adults not knowing how to raise the subject with a child and also as an adult finding it difficult to come to terms with personal feelings about bereavement and loss (Tatelbaum 1996). Today, death appears to be rather a taboo subject whereas historically, children in Britain would have been more likely to live in extended families than they are today and would have experienced at first hand losses of people familiar to them. With poor healthcare and nutrition and a high mortality rate amongst children and young adults, children of a century ago would have been more likely to experience significant bereavements and losses at close range than their modern counterparts. They may also have had a more realistic understanding of the concept of death, for example in appreciating that death is not only associated with the elderly or with violence, as some children do today (Morgan 1985). It is important to state that people continue to live within extended families in different cultures and countries, and sadly it is still the case that adequate hygiene and health facilities are not available to all. It is suggested that a cross cultural study would extend

current thinking in this area by comparing and contrasting children's conceptualisation of death in different countries. Limited research in this area however has been identified from current searches.

### How do Children Conceptualise Death?

Although it has been questioned whether children can understand what it means if somebody dies, the literature suggests that children's understanding of the concept is based upon a developmental process (Morgan 1985). Many different books describe the characteristics of children's understanding of death based on their chronological age, for example in 'Grief in Children', Dyregrov (1995) suggests that children under the age of five years have difficulty in understanding that death is final. This therefore describes in general terms how a child whose development is considered to be 'average' at this age might perceive the loss of a known individual. . This is rather a limited view however, because a variety of factors are believed to affect the individual's understanding and reaction to death. This includes their relationship with and the roles occupied by the dead person, previous experiences of loss or death, support networks available to them, the context within which the death occurred and their cognitive functioning (Rando 1984). Other factors, such as personality and resilience within the child are also important in understanding their reaction to loss. Knowledge of Attachment Theory suggests that even young babies react significantly to particular types of loss and that the effects of this might have long-term implications for the bereaved individual. Children and young

people with severe learning difficulties would generally be expected to be achieving their developmental goals much later in most or all areas than pupils of the same chronological age who are considered as being within the average ability range. It is therefore suggested that a child's understanding of the concept of death be better defined in developmental stages rather than in ages (see 'Integration of Theory and Research').

#### Consequences of a bereavement for any child

It is widely documented that when a parent has died, the child or young person who has been bereaved has to face difficult issues not only relating to the death of their loved one, but also in terms of changes within the family. The literature review raised the following issues: there may be practical changes of a material nature and subsequently emotional consequences for the child, the surviving parent may feel overcome with sadness, anger and anxiety and may not have the emotional resources to respond to their child's needs at this time or there may be a change of financial status within the family, a parent who was previously at home may have to seek employment and there may be a resulting house move or change in school. Children will also have to cope with other people's emotional arousal and changes in their behaviour at this time. The child might feel anxious about how to comfort the bereaved person and also to cope with his or her own feelings towards the death. For people with learning difficulties who are cared for in institutions, this may not be the case however as their housing and daily routine is unlikely to be affected by

a death within the family. The death of a carer or peer within the institutional setting may have as big an impact on the individual as would the death of a family member. Luchterhand and Murphy (1998) reported that the circumstances surrounding a death might complicate the grieving process for a young person with learning difficulties, however it could be suggested that this is not a unique situation for this cohort of young people as the circumstances surrounding the death of a loved one is significant for all who have suffered a bereavement.

Where information is withheld from a child, they may engage in fantasies about what has happened, or magical thinking, that they were responsible for the person dying. This may be particularly relevant where a child is young or at a young developmental stage.

### Grief and mourning in children

It is not contentious to state that the death of someone close can prove to be a major stressor for an individual and that this can result in 'strong emotional and behavioural responses' for the bereaved individual (Frude 1991). There also appears to be consensus within the literature that "for many bereaved people the slightest incident takes on a profound significance" (Frude 1991). Children with learning difficulties sometimes display behaviours that are difficult for parents and teachers to understand or interpret and these behaviours can sometimes appear to be bizarre in nature. It could therefore be suggested that following a bereavement, a

change in behaviour could be a symptom of the loss experienced, although this may not be related to cultural expectations or norms. An individual may display obsessive actions such as playing with a particular toy that they have previously shown little interest in because it was an activity that was encouraged by the dead person. This view appears to be supported through some case study evidence, although this should be treated with caution due to limited empirical support.

Grief describes how an individual responds to a loss or bereavement and mourning relates to the feelings experienced after having been bereaved. This is characterised by a process of working through feelings of pain, grief and loss. In adults, this is generally seen as having three distinct phases, Protest, Disorganisation and Reorganisation, however some authors define these further into four or five phases (Kubler-Ross 1969). Anxiety resulting from bereavement in adults relates fundamentally to the understanding that death is final and universal. Children's anxieties may come from not being told what has happened in a way that they can interpret the information effectively. Children who hear partial conversations about a death may develop creative or disturbing additions to their knowledge through their imagination. They may fear that death is contagious and worry for other members of the family. In addition, they may appear to have irrational fears because they relate an event or place – consciously or otherwise – to the loss that they have experienced.

### **What does the literature tell us about the feelings of pupils with SLD?**

Limited information is available in relation to this subject and it is suggested that for some people, SEN, and particularly individuals with SLD are perceived as a social taboo today. Within our society, which emphasises a particular view of the ideal self, people who are perceived as being different from the mainstream can be avoided or abused or feared. People with complex needs are still to a certain extent hidden in society through being educated in special schools and therefore it is difficult for people who have no experience of SEN to gain an understanding of people with diverse needs. Perhaps the fear and lack of information surrounding these taboos makes it particularly difficult to see the need for overcoming these barriers within society. The fact that pupils with SLD are still hidden negates the need for there to be high quality research about how they should be supported within the mainstream. The lack of research may feed into the anxiety felt by many professionals and parents about including children with SLD with mainstream peers and therefore segregation is viewed as a preferred method of education. This perpetuates the viewpoint that children with SLD should not be considered as 'high-profile' individuals with whom exciting and useful research opportunities are available. It is suggested therefore that the lack of information elicited in relation to pupils with severe learning difficulties is further evidence of the lower status offered to individuals with SLD within society, even amongst the professionals who are working with children who have SEN.

### **How do children with severe learning difficulties conceptualise death?**

One of the challenges in considering this question is in the fact that children with severe learning difficulties are often portrayed within the literature as being very similar in terms of cognition, social and communication skills and emotional and behavioural development. In fact, children and young people with SLD are enormously complex to consider because of the wide range of abilities that can be seen in groups of individuals who share this particular label. McEvoy (1989) suggests that pupils with special educational needs but who have good language, self help and social skills may have a more sophisticated representation of death and dying and the Author suggests that some people who have severe learning difficulties have strengths in these particular areas. Cathcart (1996) reported that some studies have suggested that the concept of death in adults with learning disabilities is similar to the development of the concept of death in children, however this does not allow for the individual differences between people with SLD and regards them as a homogeneous group in terms of their strengths and weaknesses. As described previously, a number of factors are involved in an individual developing an understanding of this concept and this is also true for children with SLD.

Consideration of the feelings and conceptual understandings of others is dependent on a certain amount of interpretation, and this is particularly the case when working with children who may not have the vocabulary or reporting skills to describe their views and opinions accurately. Where a

child or young person has severe learning difficulties, interpretation is also required and, because of the nature of their needs, the opportunities for people to recall their experiences in retrospect may also be limited.

Frude (1991) suggested that where death can be predicted, for example where somebody is elderly or very ill, the grief can be easier to cope with than in a sudden or unexpected loss. It could be argued however that for children, all losses would be viewed as sudden and unexpected because they are less able to make judgements about people's comparative ages or relating to the severity of different illnesses. This is likely to be particularly true of pupils with SLD whose social understanding and awareness may reflect that of a younger child. Staff from the school that had been involved with the working party provided an illustration of this, as some of the pupils had removed the dead child's work from the wall displays because they said that he was no longer a pupil of the school.

#### How do Children with Severe Learning Difficulties display grief?

McLoughlin (1986) suggested that children with significant learning difficulties respond to bereavement and grieve in the same way as their peers who do not have learning difficulties, although the evidence base for this statement was not recorded. This view is not universal and has been disputed, for example see Morgan, (1985).

Oswin (1991) has written one of the few books in relation to this subject, which describes numerous case studies about her work in this area. This tends to focus, without exception on the negative experiences of people with learning difficulties following a bereavement. The language of the text is deliberately emotive and there is much supposition about the negative reactions of care staff towards bereaved individuals who have learning difficulties. This may have been the experiences of Oswin at the time of her writing, however it is also true to say that many care staff form close relationships with the young people with whom they work, and would be extremely sensitive and understanding if they had suffered a loss of this type.

Persaud and Persaud (2003) developed a workshop for adults with learning difficulties who had been bereaved. They described how many of the people involved had been encouraged to hide their distress and to 'not make a scene' following a death, and this has also been reported by other sources (Oswin 1991). The reverse situation could also be considered to be true however, as people with SLD are often expected to display behaviours that would not be seen in same-age peers who do not share their difficulties. Extreme or unusual behaviours would therefore be viewed as being within the 'normal' continuum of behaviour for children with learning difficulties, whereas extreme behavioural reactions to bereavement in a young person who falls within the average range of ability might be considered culturally or socially inappropriate.

The majority of the literature in this area relates to the experiences of children who might be considered as being within the mainstream population. Section Four therefore provides an account of how children with severe learning difficulties might be affected by a significant bereavement or loss through integrating knowledge about children's responses to loss and knowledge of pupils with complex needs.

## **Integration of Theory, Research and Practice**

In considering the integration of theory, research and practice, the five objectives of the working party are revisited below. The literature did not help to provide a wide body of information about working with children who have SLD and who have experienced a bereavement. It was agreed however that general principles of working with children who are considered to be of 'normal' ability could be adapted to consider this particular group of pupils, when combined with the skills and expertise from within the working party.

### **To consider areas of bereavement and loss that are relevant to children with severe and complex learning difficulties**

Members of the working party agreed that any of the areas of bereavement and loss that might affect a 'mainstream' pupil would also be relevant to children with SLD. In addition to this, pupils with SLD might actually experience more losses than a child who does not have the same level of needs because of being removed from their peer group as part of the segregated educational system within this country, and also through being more likely to be supported through Social Care.

It was important for the group to state that the ways in which these particular children express their grief might be different to that of their same age peers who do not have learning difficulties. From the literature, an

extensive list of emotional and behavioural responses by young people to bereavement and loss was compiled. The working party considered each of these responses in turn to consider whether each behaviour could be observed within a pupil with SLD. Once this exercise had been completed, the information was then tabulated (see Appendix 2) and was summarised for use within the Information Leaflet for schools (see Appendix 3). It was acknowledged that not all children or young people would experience all of these emotions or behavioural changes and that some individuals might hide their feelings. However, this type of example was felt to be helpful to heighten awareness within school as to the possible range and intensity of feelings prompted by a significant loss.

To develop a theoretical knowledge base of the effects of bereavement and loss within this cohort of pupils

Research into feelings towards bereavement and loss would be considered a complex exercise if it was directed towards a representative sample of adults within the population, not least because the subjects of the study and the researchers might find this emotive area difficult to rationalise and discuss objectively. In looking to undertake this type of work with children, there are further dynamics to consider including the child's developmental stage and their ability to verbalise emotions and thoughts. For children and young people with learning difficulties, these complexities are heightened. A number of researchers have described the ways in which children at particular ages conceptualise death, including Brown (1999), who examined

children's levels of understanding at pre-school level, Keystages 1 and 2 and adolescence.

It was agreed within the working party that even young, or developmentally delayed children had the capacity to grieve and mourn, and that children appear to experience the same type of mourning process as adults, which occurs in distinct phases. There has been much discussion as to how many stages characterise the grieving process, however three main phases appeared to be paramount and therefore for clarity, this description was adopted by the working party to support the production of the leaflet. These are summarised as follows (adapted from Brown 1999):

The *Protest Phase* describes the initial period after being told of a death. It tends to be a short phase of numbness, unreality and disbelief.

The *Disorganisation Phase* is a period of intense despair and pain as the bereaved individual understands that the death is a reality. This period can last for many months in adults, although there are some differences of opinion as the length of time that this stage might be observed in children. During this stage, individuals may be distressed by repetitive memories or wishes of having acted differently whilst the deceased was alive.

The *Reorganisation Phase* is a period of acceptance a reassessment for the bereaved. The individual now starts to look forward and develop a new normality, which does not involve the deceased being in their life.

A child's reaction at each of these phases is likely to depend on a number of factors, including their previous experiences of loss and the implications of the loss to them. Children's cognitive development will also play a part in their interpretation of the facts presented to them and how they respond to this information. Within the literature, children's responses to death were all based upon age related norms that were not appropriate for the cohort of pupils with SLD that were being considered by the working party. By compiling information from the literature and from expertise within the group, a developmental model for understanding the concept of death was developed that was not based upon age related norms (see Appendix 1). This was later included within the information leaflet for teachers to help assimilate their knowledge of how children within their care might understand this difficult concept. It is acknowledged that this model was produced through a wide review of the literature and not through direct observation or reporting, and this is an area that would be useful to explore if this exercise was to be repeated. The limitations of this however is that it would be extremely difficult to gather a 'pre' and 'post' bereavement cohort of pupils to observe for both practical and ethical reasons. Pupils with SLD often have such complex structures for communication that any observer would have to know the pupil extremely well to be able to comment upon

changes within their personality or behaviour. The concept of Essential Lifestyle Planning is introduced later in this section as a model for helping staff and families to understand the emotions experienced by a pupil with SLD. If this type of approach is adopted, it provides a baseline of typical behaviours for an individual pupil with then makes it easier for staff and families to monitor changes and communication of a young person with SLD through their behaviour.

To elicit practical ideas and strategies for school staff after experiencing a death in the school

“Without communication structures you are more likely to behave the way you feel”

Hewitt (1998)

Pupils with severe learning difficulties may have no language or lack the complex language structures and communication skills that allow them to express feelings or ask questions in the way that children without complex difficulties are able to. Hewitt argues that communication structures help individuals to cope with their emotions, therefore allowing, ‘a more balanced and ordered emotional life’. No evidence was found however to suggest that pupils with SLD are more likely to have emotional difficulties than a person who is considered to fall within the ‘average’ range of intelligence and therefore this opinion should be treated with some caution.

The difficulties that individuals with SLD may experience with communication, language, and cognitive skills mean that it is difficult those who are working with them to understand their needs and perceptions of life. Professionals do not know exactly how a young person with SLD who has been bereaved might feel and often can only seek to do so by interpreting observations of their actions. The concept of Essential Lifestyle Planning (Smull and Burke-Harrison 1991, cited by Sanderson 1998) is generally used for preverbal pupils and completed by those people who know them well in order to be able to describe their perceptions of how the individual is feeling, and what they are communicating. The plan helps professionals working with the child or young person to learn about the relationships that are important to the individual, what they do, and about significant aspects of their life. The difference of the ESP is that it focuses on the feelings of the individual pupil, rather than their acquired level of skills, and this idea might be helpful in thinking of supporting children with SLD who have experienced a bereavement.

In an ideal situation, all children with SLD would have an ESP, which would be created following a meeting of all the individuals who know the young person well. Each person in the meeting would have an opportunity to discuss their perceptions of how the pupil communicates, and this discussion could be structured with basic questions. Information about what the child enjoys doing to relax, what stimulates them, how they behave on a 'good' and on a 'bad' day, how they show that they are communicating, how

they display that they are stressed and a range of other information could be recorded on the plan. This would give carers the opportunity to understand the child more effectively on an emotional level and therefore to be able to monitor changes in the young persons emotions more effectively. If an incident occurred within the pupil's life that may cause a significant change in emotional arousal, such as a bereavement, it would be helpful to hold a meeting to discuss the observed changes since the ESP was written. Work could then be planned to support the young person at their most vulnerable times and to provide ongoing monitoring of changes in their behaviour. This was proposed by the working party as an appropriate model for all children with SLD and was received positively by staff working with children in the school for pupils with SLD who had generated the initial concern.

#### To develop an information leaflet for teachers and school staff

From the information gained by the working party, a guidance leaflet was developed by the group (see Appendix 3). It was not possible to include detailed information within the leaflet due to the space available and members of the working party wanted the leaflet to be succinct. It was decided therefore to reduce the number of objectives that the leaflet was going to fulfil. Out of the original six objectives, it was felt that it would be important to use a theoretical framework to describe the types of loss that a child may experience, how children with SLD might conceptualise death including the staged developmental model of understanding this concept,

and how a child may react to a significant loss or bereavement. It was therefore not possible to include information about questions that the child may have or information about school policy, however during the presentation to the staff, these issues were discussed in detail.

The leaflet was targeted towards teachers within the special school who had initially requested support in developing their knowledge within this area, rather than for a wider audience. To ensure that the leaflet was clear and user friendly, it was given to colleagues within the Educational Psychology Service for feedback and these comments were then discussed and the leaflet was slightly adapted to include some organisations that could provide further support to the reader. By including the contact numbers of organisations that are able to offer further support, it was felt that individuals would be able to gain more information and support if they wished to do so.

To provide guidance for policy writing in order that all staff members were aware of school based procedures for responding to the death of a member of the school community.

Both Morgan (1985) and Brown (1999) argue for a curriculum in school that prepares children and young people for coping with losses in their lives, including death. As the working party had been established to provide strategies for staff in the event of a significant loss, it was also important to establish post-bereavement guidance for staff. The working party discussed

the fact that talking about death is uncomfortable, not least because the conversation raises worries and concerns about individual's own mortality. It was also felt that it might also raise uncomfortable feelings for staff who had experienced their own losses. This reinforced the view that it would be important to plan for how the school should respond to a bereavement as staff would be more likely to feel confident in their actions if they had a framework to work through at a time when they were perhaps feeling rather vulnerable.

During the presentation to school staff, guidance was provided in developing a policy document. It was suggested that a bereavement/loss policy should be divided into three sections, Curriculum, Short-term support and Longer Term Support. This guidance was summarised into a fact sheet (see Appendix 4) and the Deputy Head who had responsibility for Pastoral Care in school took charge of using this information to work on a school policy for coping with loss and bereavement in school.

#### Evaluation of the work

The working party considered that after the planned three-month period, the initial objectives had been achieved. It was acknowledged that it had not been possible to develop a wide theoretical knowledge base within this area, although members felt positive that it had been possible to integrate personal knowledge, expertise and experience within a theoretical framework. The information leaflet for staff was warmly received, although

not formally evaluated and it was suggested that this could be piloted in other schools in the future.

Staff in the management team expressed their thanks to the group for their work within the project and set targets within the school year for developing the bereavement policy and to discuss how some of the issues raised could be built into the curriculum.

### **Implications for future research**

There is clearly a need for further, high quality research to be conducted to explore the effects of bereavement and loss on children with severe learning difficulties. This is a neglected area within the field of child psychology and yet this information is crucial in helping to understand and support the needs of some of the most vulnerable young people within our society. The Author suggests that one reason for the lack of research that is conducted with children who have SLD is due to their lowered status and segregated position within our society, however research in this area might also be considered problematic due to methodological and ethical issues.

Techniques that are used to explore individual's experiences of bereavement or loss tend to focus on a case study or self-reporting techniques, using structured interviews or questionnaires. This may not be appropriate for individuals with SLD, particularly where they have difficulties through reporting information using language. Observations of young

people with SLD who have been bereaved may also be problematic; not only for ethical and moral reasons, but also because a researcher who is unknown to the individual will not have developed a baseline of their pre-bereavement behaviour and therefore cannot make judgements based on before-and-after comparisons. Studies in this area are therefore likely to depend on the recall and interpretations of the families and care staff who know the bereaved individual and who can therefore report on changes in behaviour during the loss and mourning period.

The proposed six-stage developmental model for understanding the concept of death (see Appendix 1) provides a starting point for individuals working with children who have experienced a bereavement. This can help families and professionals to develop an awareness about how the child or young person might be interpreting this information and to consequently support them throughout the process of mourning. Children displaying short-lived displays of anguish and who continue to ask for or seek out the individual who has died are therefore at the earlier stages of understanding the concept of death and may need reassurance that their own thoughts and behaviours are not responsible for causing the death. Children expressing fears of their own mortality and exhibiting risk-taking behaviours have a different understanding of death, which is placed at the later stages of the developmental model. These pupils will therefore require emotional support networks to discuss their anxieties. Exploring the use of the model

over time will determine the effectiveness of this approach and heighten the need for further work in this area.

## **Conclusion**

There is little information available to professionals working with pupils who have severe or complex learning difficulties in relation to talking about loss and grief. Individuals may therefore be poorly prepared in dealing with a significant loss or death within the school community which is likely to create further anxiety at a time when staff may be feeling particularly vulnerable. There are ethical, practical and emotional reasons why there is likely to be so little research within this area. It is also suggested within this assignment that pupils with SLD have been assigned a lowered status that runs throughout society and that this could be a contributory factor to the lack of empirical evidence relating to the needs of pupils with SLD. This assignment argues for greater consideration into examining how significant life events might affect children and young people with SLD and also that more approaches should be developed to identify and measure the behaviours of pupils with SLD.

Although links can be made between the experiences of all children who experience bereavement and loss in that they are likely have similar emotions and pass through similar stages of grief, children with SLD are more likely to show their feelings through their behaviours than through language. It is acknowledged however that children with SLD cannot be considered to be similar in their personal strengths and weaknesses and that they should be viewed as individuals as any other child would be. It is

suggested that schools are beginning to consider a more emotional curriculum alongside the academic curriculum and that this is an effective way to help children cope with anxieties. As an extension of this type of curriculum content, it is proposed that talking about loss and bereavement at school would be of benefit to many children, as all children experience some losses in their lives through normal developmental changes. Children with SLD may experience more losses than children without special educational needs and therefore it would appear to be even more important to prepare them for changes within their lives.

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## **Appendix 1: A Developmental Model for Understanding the Concept of Death**

**STAGE 1:** Characterised by separation anxiety, seeking the absent person. Attachments formed to primary caregiver. No real concept of death. Displays of anguish are shortlived.

**STAGE 2:** In this stage, death is viewed as a temporary and reversible state, although there is some understanding that death is linked to separation. Individuals at this stage are not aware that everybody dies and in particular that they will die. Children or Young People at this stage may feel that it can be caused by magical thinking (for example because they wished their sibling dead after a fight). They may believe that their 'bad' behaviour has caused a death. Individuals who are at this stage may ask questions that can appear insensitive to adults who are unaware of the reasons for the questions.

**STAGE 3:** Questions are also asked at stage 3, which is characterised by the person understanding that death is permanent. The child or young person does not think that they will die and may just relate the causes of death to those that they have witnessed on the television or in life.

**STAGE 4:** The individual realises that everyone, including him or herself will die and may become anxious about this. Questions may become more specific in terms of asking familiar adults about when they will die and asking for clarification about euphemistic terms.

**STAGE 5:** At stage 5, individuals may try to challenge death through risk taking behaviours. Questioning may relate to more abstract concepts such as life after death and ethical debates.

**STAGE 6:** Stage 6 is difficult to define because there is no logical ending point to the concept of death, which may change for individuals throughout their lives. At this stage however, death is seen as part of the life cycle. Individuals may fear their own morbidity and the loss of others, particularly when they are reminded of this fact, but it is not a preoccupation for them. Generally individuals will have found ways to cope with this, perhaps through a religious belief system, or by organising practicalities of funerals, or organ donation.

**Appendix 2: Feelings and observable behaviours that may be seen in children with SLD who have experienced loss**

Feelings	Observable behaviours
<p>Numbness            Sadness            Longing            Depression            Loneliness            Feeling abandoned            Powerless            Frightened            Cheated, that life is not fair            Guilt            Anger            Anxiety about the well being of others            Denial            At fault            Panic            Withdrawal            Hostile to the deceased            Idealisation of the deceased            Disbelief            Rejection of former religious beliefs            Separation anxiety            Blame            Embarrassment</p>	<p>Tearfulness            Regressive behaviour            Physical illness            Poor appetite/eating disorders            Sleep disturbance            Enuresis            Self harm            Acting out behaviours            Unsociable to others            Lack of concern for self            Shortened attention span            Poorer performance in classwork            Forgetfulness            Assumption of deceased's mannerisms            Aggression            Denial            School refusal            Fantasies/hallucinations about the dead person            Stealing            Nail biting            Difficulties in sustaining relationships            Rejection of affection            Breathlessness            Obsessive rituals</p>

**Appendix Three: Information Leaflet for Schools**

**Helping Children with**

**Learning Difficulties**

**Cope with**

**Bereavement and Loss**

*Guidance for staff working with pupils who have complex learning needs*

Types of loss that might be experienced

Any child may experience loss through changes in routine, changes in school staff, moving house, a family breakdown, or the death of a family member or pet. Some information is available from research about how children respond to these particular situations, although this generally relates to children who fall within the average range of development and therefore little is recorded in relation to the affects of bereavement and loss in children with more complex needs

How do children with learning difficulties conceptualise death?

McLoughlin (1986)\* suggested that children with significant and profound learning difficulties display similar responses to bereavement and loss as individuals without learning difficulties.

Publications that consider how children respond to bereavement and loss suggest that their understanding of the concept of death is broadly based upon the age of the child. In reality, a variety of factors affect the individual's understanding and reaction to death including their relationship with the dead person, their previous experiences of loss, the support networks available to them, and their personality type.

\* McLoughlin, I. (1986) Bereavement in the Mentally Handicapped British Journal of Hospital Medicine , 36(4) 256-6

Development of concept of

Children a to a sign differently understand is not always age and suggested

STAGE 1: no real cor is short live

STAGE 2: reversible. Individuals could be o behaviour.

STAGE 3: but not s everyone.

STAGE 4: death is anxieties in

STAGE 5: death rela such as life

STAGE 6: cycle. Copi for dealing relating to

### How are children and young people affected by grief?

Grief describes how an individual responds to a loss or bereavement and in adults and children this is generally seen as having distinct phases. These are summarised below (adapted from Brown 1999\*).

#### **The Protest Phase**

After being told of a death people tend to experience a short phase of numbness, unreality and disbelief.

#### **The Disorganisation Phase**

A period of intense despair and pain as the bereaved person copes with understanding that the death is real. This period can last for many months in adults, although there are some differences of opinion as to how long this stage is seen in children.

#### **The Reorganisation Phase**

This is a period of acceptance a reassessment for the bereaved. The individual now starts to look forward and develop a new normality, which does not involve the deceased being in their life.

Brown, E. (1999) *Loss, Change and Grief, An Educational Perspective*. London, David Fulton Publishers

### Feelings and behaviours associated with mourning in children

Mourning relates to the feelings experienced after having been bereaved. Possible feelings include: Numbness, sadness, longing, loneliness, abandonment, powerlessness, fear, guilt, anger, anxiety, denial, panic, and disbelief.

Behaviours relating to these feelings may include:

Tearfulness, regressive behaviour, physical illness, poor appetite, sleep disturbance, enuresis, self harm, acting out behaviours, shortened attention span, forgetfulness, assumption of deceased's mannerisms, aggression, rejection of affection, breathlessness, and obsessive rituals

Not all children or young people would experience all these emotions or behavioural changes and that some individuals might hide their feelings. Pupils with learning difficulties may lack the complex language structures and communication skills that allow them to express feelings or ask questions about bereavement and loss in the way that children without special needs are able to.

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## **Appendix Four: School Policy**

### **Developing a School Policy in relation to Coping with Bereavement at School**

These guidelines are designed to prompt discussion and ideas within the context of your school.

A policy should aim to consider three main areas within school, *Curriculum*, *Short-term support and longer-term support*.

*Curriculum* relates to the everyday work in school that may prepare the children and young people for experiencing losses through discussion in science, religious studies and PSHE. In this context, preparation for life changes and 'small losses' will help staff to understand the pupils' reactions to change. This will enable them to discover ways to support the pupils in the event of a death or significant loss. It is important to share the content of this work with parents who may feel that this type of support is more appropriate to be raised within the home.

Specific techniques such as Essential Lifestyle Planning might be helpful to build a baseline of 'normal' behaviours for preverbal pupils that can be monitored and revised over time, but particularly in the event of a bereavement or significant life event.

*Short-term support* considers the procedures that could be put into place if somebody from within the school community died. This should include the following information within the policy:

- Who should break the news about a death?
- What exactly will the children be told?
- How will they be told? (As a class, individually etc)
- When will they be told?
- How will this information be communicated to parents and other staff?
- What questions might the children ask?
- What links will be made with the family of the deceased?
- Whether it is appropriate for staff to show their emotions to the children.

*Longer-term support* relates to the ongoing support of the pupils whilst they are working through the process of mourning. This might be through direct work with the pupil by referring them to appropriate professionals in the field, or in supporting school staff who have concerns about what a child is thinking and feeling. At this time, it is also important to consider individual the development needs for individual members of staff.

## **Appendix Four: Continued**

Useful publications and Resources:

### **Curriculum Resources**

Cooley, J and McGauran, F., (2003) Talking Together About Death, A Bereavement Pack for People with Learning Disabilities. Dover, Smallwood Publishing Ltd

### **Short-Term and Longer-term Strategies**

Nagraj, R., and Moddia, B., (1995) Bereavement and Loss in People with Learning Disabilities. Oxford. Oxfordshire Learning Disabilities NHS Trust

Oswin, M (1991) *Am I Allowed to Cry* London. Souvenir Press. Chapter 6, 'Recommendations and Suggestions'

### **Other Organisations**

CRUSE, Cruse House, 126 Sheen Road, Richmond, Surrey. (Also see local telephone directory for details)

**ASSIGNMENT THREE:**

**WHAT IS THE ROLE OF THE EDUCATIONAL  
PSYCHOLOGIST IN SUPPORTING CHILDREN AND  
YOUNG PEOPLE WITH MEDICAL NEEDS?**

## **WHAT IS THE ROLE OF THE EDUCATIONAL PSYCHOLOGIST IN SUPPORTING CHILDREN AND YOUNG PEOPLE WITH MEDICAL NEEDS?**

### **Aims and Scope of the Assignment**

Following the publication of 'Access to Education for Children and Young People with Medical Needs' by the DfES in November 2001, two Educational Psychologists (EPs) were appointed as EP representatives for Pupils with Medical Needs within a Midshire county. As part of this role, consideration was given to local and national guidance. This indicated that EPs should contribute to supporting this group of children purely as part of their statutory function when contributing to a Formal Assessment of a pupil's needs.

It was felt within the Midshire Educational Psychology Service (EPS) that a wide range of professional experience and expertise was held within the service that might benefit this cohort of pupils, over and above that of the Statutory Assessment role. In exploring whether this was the case, the Author considered the psychological issues that are faced by children and young people with medical needs and subsequently how Educational Psychologists might address these issues using their unique training, experience and skills. This information was shared with the Acting Chief Educational Psychologist (CEP), in order to contribute a psychological

perspective to the Midshire Council Policy document. As a result of this work, the role of the EPS was extended, although not quantified, within the final Council Policy.

This assignment argues that EPs are in a unique position to contribute a wider understanding of how to support children and young people with medical needs. Information gained from psychological theory and research in this area appears to support the view that there is a requirement for this involvement and staff within the local context also felt this to be the case.

Ways forward for EP practice are discussed and it is suggested that Local Educational Authorities should be prepared to adopt a flexible and committed approach to meeting the needs of this group of pupils. This perspective is illustrated by a case study of young person with medical needs that describes how the support offered by the EPS to the pupil, family, LEA, schools and supporting agencies was invaluable to meeting the needs of the particular pupil.

## **Practice and Content**

The DfES issued the 'Access to Education for Children and Young People with Medical Needs' document in November 2001 as part of the Excellence in Schools initiative. This document is described as being, "statutory and good practice guidance" (DfES, 2001, p3) and formalises the minimum standards required for supporting pupils who have medical needs that prevent them from attending school.

Following the issue of this document, two Educational Psychologists (EPs) within a Midshire Educational Psychology Service were appointed as EP representatives for Pupils with Medical Needs in the northern and southern areas of the county. The EP role, as described within both the national and local guidance was unambiguous, for example the Access to Education document described how educational psychologists might play a useful role in supporting this cohort of young people as part of their statutory duties. It was felt within the EPS that it would be important to consider other areas of support that could be provided by Educational Psychologists in supporting children and young people with medical needs within the education system.

This assignment attempts to address this issue by answering two main questions:

- What issues, relevant to Educational Psychologists, are faced by children and young people with medical needs?

- How can Educational Psychologists support children and young people with medical needs, using their unique training, experience and skills?

In addressing these questions, the Author considers the assessment, reporting and monitoring roles of educational psychologists, and also the wider involvement that EPs might play in supporting pupils with medical needs. This may include working in partnership with schools, families, support agencies and also with the pupils themselves to ensure a high quality and joined-up approach to meeting their needs.

In addition to considering these questions, the local perspective relating to the support of children with medical needs was considered. It was agreed within the EPS that recommendations would be made to the Local Education Authority (LEA) in order to contribute a psychological perspective to the working party responsible for developing the LEA policy in this area.

What issues, relevant to Educational Psychologists, are faced by children and young people with medical needs?

Within this assignment, it will be argued that many of the issues faced by children and young people with medical needs are relevant to Educational Psychology on individual, family and systemic levels. Educational Psychologists have much to contribute to the understanding of children's

psychological responses to illness, a much under-researched area, and also how a child's illness may impact upon parents, siblings and other family members.

In addition to working with children and families, EPs play a significant role in promoting successful inclusion within schools, which is particularly important in considering how children with medical needs might be reintegrated back into school after a significant period of absence. This may involve consultation with staff to help develop a picture of the child's individual needs as well as interventions with pupils within the school to successfully promote social inclusion.

As part of a multidisciplinary team of support services, Educational Psychologists are able to support colleagues within the Health Service in understanding the factors that may contribute to a child's psychological well-being prior to, or following a period of illness. As there are well-documented studies correlating emotional well-being to physical health, this can only be of benefit to the sick child, their family and the support services involved.

**How can individual Educational Psychologists address these issues using their unique training, experience and skills to support pupils with medical needs?**

The Access to Education guidance (DfES, 2001) emphasises the opportunity for support services to work together in a unified way to help children and young people with medical needs. In Chapter 2 (2.4, p. 11) of the document it is stated that in developing a policy for supporting this cohort of pupils, links should be made with a range of appropriate agencies including the Educational Psychology Service. The EPS is not seen as one of the key partners in this support, and guidance about the EP role describes liaison with other agencies and assessment as a statutory function as being the most significant part of the role. Within this assignment, it will be argued that although the statutory function is a necessary one, EPs may form an integral part of the network of support to the children and young people who have significant medical needs. This contribution should be considered as an important element of support for the child and their family and should not be dependent on whether the pupil was considered as having special educational needs prior to their illness. This proposal will be discussed in more detail within the 'Integration of Theory and Research' section of this assignment.

**Midshire Perspective**

Following the Access to Education Guidance being issued, a working party was developed within a Midshire Authority to develop a Countywide Policy

to supporting children and young people with medical needs. The working party reported to the Acting Chief Educational Psychologist (CEP) who also managed the Pupil Referral Units (PRUs) and services for pupils educated other than at school (EOTAS). Initially, members of the Educational Psychology Service were not formally invited to be part of the working party, however the two EPs who had been asked to take responsibility for supporting children with medical needs within the County were provided with information about the progress of the party and were consulted by the Acting CEP before the Policy was finalised. Consultation also took place between the EP responsible for Children with Medical Needs in the south of the County and the Home Tuition Coordinators from the PRU in preparation for the role.

The Midshire Policy (see Appendix 1) adheres closely to the DfES guidance and therefore the described role of the EPS is limited and not quantified. This assignment argues for EPs having a wider representation in supporting children and young people with medical needs, initially by exploring psychological theory and research in this area and subsequently by integrating this with ways forward for EP practice. It will be argued that EPs are in a unique position to support this cohort of young people providing that the LEA adopts a flexible and committed approach to managing support for this vulnerable group of pupils.

## **Psychological Theory and Research**

**“Medical conditions may have a significant impact on a child’s experiences and the way they function in school. The impact may...affect cognitive or physical abilities, behaviour or emotional state...or through the psychological affects that serious or chronic illness or disability can have on a child or their family.”**

**SEN Code of Practice (DfES, 2001)**

### **Background**

**It is reported that 100 000 pupils cannot attend school each year through illness or injury (DfES, 2001). Many of these medical conditions will be considered as routine and short lived, but for some, there will be longer-term implications due to the intensity, prognosis, or required management of the illness.**

**Within the Access to Education document (DfES, 2001), equal emphasis is placed upon the education of pupils with both physical and mental health needs, and it is estimated that 10% of pupils aged from 5 to 15 will have mental health disorders (Office of National Statistics). The Access to Education document (op cit) emphasises the need for educational experiences to be appropriate to the medical condition of the individual pupil as well as to their age and ability, and therefore this distinct group of pupils**

may present a particular challenge for their teachers. The requirement for teachers to differentiate the curriculum in relation to a particular medical need may cause anxiety for school staff and therefore a need is identified for schools to access high quality information and research in this area. This is an area in which educational psychologists (EPs) could play a significant role, through using their specialist knowledge of applied research, child development, and working within educational systems. EPs could also consider particular aspects of research that are essential to developing an understanding of children's psychological responses to illness. A review of the current literature in this area is considered hereafter.

### **Children's psychological responses to illness**

A number of challenges are presented when considering the literature in relation to children's psychological responses to illness. The first relates to the level of coherence between studies, which tends to be limited. Bradford (1996) reports that from the studies available, each represents a specific cohort of pupils and uses different research methodologies and this makes it difficult, when reviewing the literature, to develop clear views as to how these disparate findings marry together.

A second challenge relates to the validity of assessment tools used within the research. Data in this area is generally collected either through the use of case studies (Bradford, 1996), or through administering structured interviews or ratings scales to relevant individuals. These may include

canvassing medical staff (Genevro et al, 1996), parents of the ill child (Bradford, 1996), or the child themselves (Pretzlik, 1997). The majority of the research conducted in this way is completed on a small scale, and therefore questions should be raised in relation to the reliability and validity of the results. Case studies may generate a good deal of rich, qualitative data, but the reported experiences of a single individual should be interpreted cautiously (Cohen et al, 2000).

A third challenge of considering the literature in relation to children's psychological responses to illness is presented when gathering the perceptions of children with medical conditions, which may be unstable over time depending upon the physical or mental health of the child at the time of being surveyed for their views. The level to which children's views can be effectively elicited may also be restricted by their age, cognitive skills, language development or relationship with the researcher.

There are many reports and descriptions of families receiving concurrent intervention and support from up to twenty different agencies, including those from Health, Education, Social Services, voluntary services and the DSS (Stein and Wooley, 1990). One implication of this finding relates to the use of medical professionals to gather data about children's responses to illness. It is essential that any professionals completing interview schedules or questionnaires about children under their care should disclose the level and duration of contact that they have had with the child in order to ensure

that their reports are valid for a particular study. The nature of the relationship between the sick child and the professional involved in research studies is often not disclosed (Genevro et al, 1996).

An example of small scale research using parent-completed scales was reported by Stein and Woolley (1990), who conducted a study in which a higher proportion of children referred to a hospice were seen as 'experiencing considerable psychological problems' when compared to a control group of 'ill children' on the Rutter A-2 Scale, which considers whether a child is displaying emotional and/or behavioural problems. This research involved only small numbers of children (n = 15) however, and therefore would need to be replicated more widely to include a more representative sample and to reduce the possibility of bias. This research could also be considered unreliable because it was the parents of the sick children who completed the Rutter A-2 scales. The parents may have found it difficult to provide objective reports at a time when they were worried about their child's well-being, which is likely to have affected the way that the ratings scales were completed. Parents may also have projected their own anxieties when answering questions about their child, creating another source of bias.

Larcombe (1990, 1995), who has completed extensive research on behalf of the Cancer Research Campaign, reports that children may become anxious after treatment due to fears of a relapse and this can be displayed

through a range of emotional and antisocial behaviours. Larcombe (op. cit.) also described the need for teachers to account for the affects of drugs in their differentiation of class work, with sick children being more likely to display a more emotional response to the curriculum than their well peers. This advice relates directly to the recommendation in the Access to Education (DfES, 2001) document about how differentiation within the classroom should account for the medical condition of the child, however there is little information to indicate how this should be achieved. The Author of this assignment suggests that training packages for schools should be developed in this area to develop awareness of the issues raised by Larcombe's (op. cit.) research.

Little research is available to consider the longer-term implications of childhood illness on an individual's future success. Ross (1984) suggested that children who have been treated for cancer are less active participants in new activities, take fewer risks in their approach to tasks and have smaller groups of friends. These hypotheses have not been substantiated by a representational or full-scale study and therefore further work is clearly necessary in this area. Within this study, Ross (op cit) also gives little consideration to the possibility that children with cancer could display a diverse range of reactions to their illness, both in the short and longer-term. Psychosocial factors connected with how children and families adjust to the news of a serious illness have been widely explored within the literature and

particular risk and resilience factors have been identified, which include the severity and length of the illness, the child's conceptualisation of the illness, and the quality of support that the individual receives (Bradford, 1996). A vacuum therefore exists within current research into considering the short, medium and long-term implications of childhood illness and the factors associated with successful and less successful outcomes at each stage. This research could be developed and implemented by educational psychologists in order to develop interventions for children with medical conditions. It is anticipated that such interventions would encourage children to develop effective coping mechanisms to support the positive management of their illness.

There is a general consensus within the literature that children have a more positive psychological response to illness in situations where life can remain as similar as possible to the time before their illness developed (Curnick 1990, Jeffrey 1990). This 'normality' includes attending school to encourage the maintenance of routines and a sense of discipline for the child. It could also be argued that this experience provides the child with manageable academic challenges and gives them some control in their lives – a contrast to the lack of empowerment they may feel because of the treatments that they face due to their illness. Fithian (1984) stated that 'normal' expectations of the child should be made, for example that absence from school should not be excused without question because it is expected that the individual would miss some schooling through illness. This reinforces

the need for training to be made available to school staff in order to provide them with the knowledge and skills for the differentiation and management of sick children. In addition, support could be made available to the parents of children with medical needs in order to help them appreciate the need for routines and the role of school over and above that of being an educational establishment.

One factor that appears to be influential in a child's ability to adapt to experiencing poor health is their conceptualisation of the situation. There is little research evidence to specifically consider how children conceptualise illness and therefore developmental models tend to be used to explore this area.

### **How do children conceptualise illness?**

Studies to consider how children conceptualise illness tend to adopt a Piagetian perspective (Bibace, 1982). These reports argue that observation of children's behaviours and verbal interactions indicate that a developmental understanding of illness is present and that children combine knowledge with fantasy to establish a personal truth (Blos, 1978). Frude (1991) supported this perspective and reported that young children may perceive that illness is a punishment for poor behaviour whilst older children begin to understand a more realistic viewpoint. Blos (op. cit) described a fundamental change in children's understanding between the ages of 8 and 9 years, which is closely linked to Piagetian thinking. This view might be considered rather limited however, as in

reality a wide range of factors could contribute to children's understanding and conceptualisation of illness (Bradford, 1986). A broader picture is provided by Genevro et al (1996), who considers a functionalist perspective in which children's understanding of illness is based upon a number of factors including their age, developmental level, individual differences and earlier experiences of medical or health interventions. This viewpoint is particularly helpful as it acknowledges that the rate at which children's understanding develops is not uniform, or determined purely by chronological age; rather that other factors, such as their socio-emotional development and cognitive differences may impact upon conceptual development. An area of psychology that links closely to that of serious illness is that of loss, as most medical conditions involve some loss of functioning. Models of loss also tend to follow a developmental perspective and therefore, whilst the developmental model should not be ignored, it should be placed in context to account for the fact that a more complex interaction between factors coordinate to contribute to a child's conceptualisation of illness. One aspect of the research that appears to have been neglected within the literature is how perceptions of illness are influenced by religious and cultural factors. This area links closely to research into how individuals form attributions about particular situations (Weiner, 1986) and is an area that warrants further study.

### Family Issues

Information drawn from both health and social psychology provides valuable information about the significant impact of family management towards childhood illnesses and the effects of this upon the well-being of the child.

This information is helpful to educational psychologists who may provide a useful role in supporting families who are experiencing this situation. Family perceptions of a child's illness are also an important area for wider study, as Bradford (1997) stated that the severity of a disease from the viewpoint of the parents, rather than the medical practitioners had a direct bearing on how a child adjusts to an illness.

The literature indicates that a number of factors will affect how successfully a family responds to life with a child who is experiencing a major illness. Family systems need to adapt to having a sick child on a practical, emotional and cognitive level, and coping mechanisms will depend on a number of factors. These include not only the nature and manifestation of the illness but also the amount of change that is necessary within the family to meet the needs of the ill child. A sudden illness or injury will therefore provoke a different reaction within the family to a gradual onslaught illness, or an illness that parents have been aware of within the perinatal period.

There is dispute within the research about whether socio-economic factors affect how significant an impact the child's illness will have upon the family unit. Fithian (1984) reported that a family's financial status will impact on their ability to adjust to a child's illness, whilst Bradford (1997) considered analyses of the literature and concluded that socio-economic status is not linked to child and family adjustment to illness. It could be suggested however that other factors related to the family's financial circumstances are

more important to how well they cope in this situation, for example the flexibility of parental working arrangements, or whether the parent is provided with compassionate leave to accommodate the child's recovery period may also be implicated. Bradford identified other variables within the literature that appear to have a direct affect upon family adjustment to illness including levels of family cohesion or other stresses, the amount of conflict within the family and levels of communication.

Fithian (1984) stated that the guilt and anxiety experienced by the parents of sick children can lead to them being overprotective, however these views appears to be based on supposition, rather than empirical evidence. Frude (1991) also argued that parents of a sick child may find it difficult to treat the individual as a regular family member and suggested that this could result in regressive behavioural issues in the child, such as thumb sucking or nocturnal enuresis. Frude (op. cit.) considers these regressive behaviours to be a direct result of the parental response to the child being ill, but he does not consider an alternative viewpoint, that the behaviours relate to the child's emotional response to the illness and their own personal stress rather than being the result of parenting style. It should also be stated that some of these observed behaviours may have been evident in the child prior to their illness and therefore it is behavioural changes that are most important to identify in children with medical needs.

### Issues for Educational Professionals

When considering the psychological implications for pupils with medical needs, a number of issues for educational professionals are raised within the literature from both philosophical and practical perspectives. One function of schooling is that it is supposed to prepare a young person for their future adult life, which could be seen to cause anxiety for parents of a child with a life limiting illness (Jeffrey 1990). An alternative viewpoint is offered by Ross (1984) however, who states that attending school can symbolise a future for sick children and their parents and that this encourages a positive outlook and feelings of hope.

From a practical point of view, an important issue for children and young people who have missed school due to a medical condition relates to the physical changes that they might experience as a result of their illness (Curnick 1990). An area that is under-researched within the literature relates to the fact that medical conditions may also result in 'invisible' impairments, such as difficulties in concentration, and it is this type of problem that is particularly relevant to educational professionals in schools.

The literature suggests that invisible impairments are particularly relevant for pupils suffering from mental health disorders (Atkinson and Hornby, 2002). They argue that teachers are, "...uniquely placed to influence the mental health of children" (pg 3), however it could be argued that this role is not part of the teaching curriculum and is one that teachers feel neither

qualified or competent to take on board. Anxieties raised by teaching staff resulting from work with pupils who have mental health needs could be supported through the school's involvement in initiatives such as 'Healthy Schools' and also by promoting emotional literacy within the curriculum.

There is some evidence to suggest that school staff lack experience in working with children who have severe medical needs (Jeffrey 1990) and this aspect of school life is generally not addressed within teacher training or development courses. Ross (1984) reported that a class teacher may have fears about answering challenging questions from the sick child or their peers and that the children within the class may worry about how to react and respond to the sick child. As a result of this finding, Ross (op. cit.) recommends that the class teacher should discuss the child's medical condition with them outside of the classroom environment. Within the chapter it is not acknowledged that this recommendation could increase anxiety for both the class teacher and the pupil, and it could be argued that the pupil could find this questioning intrusive at a time when they were already subject to some scrutiny by medical personnel.

Fithian (1984) argues that school staff should be cautious that pupils are not manipulating staff by using their illness to abandon classes that they do not enjoy, however there is little evidence to suggest that this is a common practice amongst young people with medical needs. This research does highlight the necessity for agencies to work together to produce a picture of

expectations for the sick child that does not focus purely on their medical symptoms and also to consider the factors that promote school attendance for pupils with significant illnesses.

There is little information in the literature to consider the relationship between illness and school attendance, however there is some limited evidence to suggest that there are gender and demographic factors linking the extent of school absence in pupils with cancer (Ross 1984). In a unique study, Ross reported that boys with cancer have less absence from school than their female counterparts, although it was not made clear from the conclusions of the study whether this was because the boys and girls under scrutiny developed different types of cancers with different effects upon the individual, or whether parenting factors were indicated. There are conflicting views within the literature in relation to how gender influences children's response to illness. Bradford (1997) stated that gender was not associated with adjustment to illness, however Genevro et al (1996) categorised children's representations of 'going to the doctor' and on the basis of this study suggested that girls' representations were significantly more complex than boys. Within the same chapter that explored the gender differences relating to the school attendance of sick children, Ross (1984) suggested that demographic factors are also a significant factor in this area. He stated that children with cancer who live in small communities have less time away school than pupils who live in larger communities and hypothesized that this is due to the relationship that parents have with the school and the school

community. This hypothesis is flawed as it is based upon the assumption that parents in small communities feel more involved with their school than those in larger communities, whereas it could be suggested that the speed at which a child returns to school following a period of illness might be influenced by other factors, such as the availability of hospital and home tuition services. These are likely to be more easily accessible in urban rather than rural communities, a likelihood that is not raised in Ross's work.

As a result of considering the literature in this area it is clear that there is a need for research to be conducted and communicated to school staff in order in order to promote the successful inclusion of pupils with medical needs into schools.

### Issues for Health Professionals

Bradford (1997) considered adjustment theories from health psychology and two key factors that related directly to the work of healthcare professionals, were implicated in positive family adjustment to having a sick child. The first of these factors related to the quality of communication between patients and doctors and second to the ward or healthcare environment. Frude (1991), found some evidence to suggest that health professionals do not always have a good understanding of how children conceptualise illness, which can impede their ability to communicate in an appropriate manner with younger patients. There is a clear need for health professionals to develop their skills in this area to reduce stress for the child

and their family as evidence suggests that the management of stress may contribute to the outcomes of an illness (Lark and Fosson, 1989).

Another area of research that is important for health professionals relates to the risk factors that are implicated in reported childhood illnesses. Lark and Fosson (1989) report that high levels of stress within the family increases the risk of childhood accidents and Greene et al (1985) link family stress to the onset of certain childhood diseases. This research appears to be supported by Leaverton et al (1980) who associated family stress with diabetes, asthma and even some types of cancer. The reporting of this research however does not allude to the fact that there might be a reporting discrepancy within the classification of these accidents, injuries and illnesses. Children living in families who are experiencing high levels of stress are more likely to suffer physical abuse (Atkinson and Hornby 2002) which would probably be reported as a childhood accidents to health professionals. Families who live on a low income may find it more difficult to provide healthy food and adequate housing for their children, which could be one reason as to why low income has been linked to higher risks of asthma and diabetes in children.

### **Conclusions drawn from the literature**

It appears that psychological research has much to offer in developing an understanding of the needs of children with medical conditions. Particular themes within the literature relate to the need for high quality and

coordinated research to be conducted in this area to promote evidence-based practice amongst professionals and the necessity for training in schools. By integrating research with practice, applied psychologists working in educational settings are in a unique position to offer this type of support to children, families, schools and other professionals. An important consideration of this possibility relates to the implications of working within the constraints of a real-world context however, where the role of the educational psychologist is often considered only in terms of their statutory function. The following chapter aims to explore how a necessary and creative role could be developed for LEA psychologists in supporting pupils with medical needs.

## **Integration of Theory, Practice and Research**

This assignment aims to reflect upon the role of the educational psychologist (EP) in supporting children and young people with medical needs by considering the following questions:

1. What issues, relevant to Educational Psychologists, are faced by children and young people with medical needs?
2. How can Educational Psychologists support children and young people with medical needs, using their unique training, experience and skills?

The literature suggests that many issues faced by children and young people with medical needs are relevant to EPs and awareness of removing barriers to participation and learning in schools has been heightened by the 1995 Disability Discrimination Act.

Key themes relating to the role of the educational psychologist in this area that were identified within the literature include:

- Helping parents and professionals to understand how children conceptualise illness
- Promoting effective communication between professionals and the young person involved to reduce stress and promote positive outcomes for the child

- **Developing and delivering training packages for teachers and school staff**
- **Identifying vacuums within the research and conducting high-quality, coordinated studies in this area**
- **Interpreting data/generating alternative hypotheses**
- **Promoting information that could directly influence medical outcomes for the child, for example relating to protective factors**
- **Supporting children, families, schools and other professionals**

In questioning how EPs can support children and young people with medical needs, it is suggested that a flexible style should be adopted to encompass individual and systemic approaches. An example of how a midshire Educational Psychology Service was able to respond in a responsive, coordinated way to support a pupil with significant medical needs is reported within this assignment in order to illustrate how a flexible package of support can be offered within a real-world context (see Appendix 2). Although case studies need to be considered cautiously, this example provides an illustration of how support can be offered to children, families, schools and other professionals. In addition to the case study provided, other elements of support are discussed hereafter in order to integrate theory with practice.

## Support to the young person

### Understanding illness

For children with severe medical conditions, the world may appear rather a confusing place. For those who are hospitalised or housebound, social support structures may be removed and new routines will have to be acquired. Within this isolated state, the individual could become more focused upon their illness and the negative aspects of their life and the child's self esteem might be low, not only due to the emotionally draining effects of being ill, but perhaps also due to a loss of independence and increased dependence on others. Educational psychologists have much to offer the understanding of how children perceive illness and the factors that promote emotional well-being.

Research indicates that children's understanding of illness appears to follow a developmental process, similar to their understanding and knowledge of bereavement (Frude, 1991). Frude suggests that where young children are not prepared or supported in appropriate knowledge about their illness, magical thinking could result adding to children's fears about their physical or mental health. It is important that this perspective is not viewed in isolation however, as this picture does not allow for extraneous factors to influence the child's understanding of their condition. Williams (2002) conducted a study in which she reported that although children's understanding of illness undergoes developmental changes, their knowledge can be extended through educational intervention. Williams'

(op.cit.) approach was to provide developmentally suitable, factual information for children within the context of peer group discussions and the results of this small-scale study indicated that a significant difference could be made to extending the knowledge of the children involved. This is a real-world example of how psychological intervention might support children with medical needs and is significant because children's understanding of their condition is important in how positive they feel about alarming experiences such as medical treatments and hospitalisation.

#### **Children's rights and views**

Another important contribution of educational psychology in supporting children with medical needs could be in ensuring their views are heard and acknowledged. The United Nations Convention on the Rights of the Child states that young people have the right to access information and for their views and opinions to be expressed and be listened to. It states explicitly that this information should be given and received in an appropriate manner reflecting the child's age and developmental level. The educational psychologist's knowledge and experience of child development can allow them to gain the opinions and feelings of the young people involved in a skilful and appropriate manner. This not only enables the voice of the child to be heard but also provides a forum for the child's views to be communicated within a wider audience.

## **Interventions for emotional needs**

**Raising awareness of the possible emotional and behavioural responses to anxiety is an important part of the psychologist's role. Work with specific groups of young people, for example in anger management sessions or stress management as well as parenting groups for pre and postnatal young people is also part of an educational psychologist's remit which could be of benefit to this cohort of children and young people.**

**The SEN Code of Practice (DfES, 2001) suggests that school's pastoral systems should allow the young person to access support staff, including an educational psychologist, if they wish to discuss any 'health related or other problems'. It has not been the author's experience that pupils with medical needs who are out of school are routinely raised at planning meetings and it could be questioned whether young people know of the educational psychology service and what their role is in school. In defining pupils who have mental health disorders however, the Office of National Statistics include pupils with conduct disorders and emotional disorders who might display separation anxiety, sleep disturbances, negative or anxious, self-harm, eating disorders and school refusal. These are all difficulties that present themselves to Educational Psychologists on a regular basis as part of generic casework. In addition to this psychologists are aware of how behaviours in school that might be interpreted as challenging or risk taking, can be a communication by the pupil of their own mental health needs.**

## **Linking services**

**Children with medical needs may receive support from hospital schools, home tutoring services, and Pupils Referral Units (PRUs) as well as their own mainstream or special school whilst experiencing a period of illness (Pretzlik, 1997). Educational Psychologists can provide links between these services for monitoring pupil's progress and in supporting a cohesive approach to meeting a child's needs. It is important that pupils are provided with an education that is appropriately differentiated according to the pupil's age, ability and their ability to cope with the curriculum because of their illness and their emotional response to learning as a result of this (Access to Education, DfES 2001). In addition to this, although a medical diagnosis does not mean that a pupil has special educational needs, a medical condition might increase the likelihood that pupils will have greater needs in their learning than the majority of their peers (DfES 2001). Individual pupils with medical needs may therefore, in addition to receiving support to manage their illness, also need support to meet their special educational needs. Educational Psychologists may subsequently provide an assessment and monitoring role as well as a possible statutory role, if the pupil requires the protection of a Statement of Special Educational Needs.**

## **Family work**

**Psychologists are able to help families to understand that the child needs to be treated as a person with an illness, rather than an ill person. This**

includes discussing issues relating to the child's developmental understanding of the concept of illness and specific issues, for example relating to rules, boundaries and discipline. Raising awareness about the psychological relationship between illness management and prognosis may help in dealing with these complex issues at home, for example in helping parents to understand that giving children gifts or allowances because they are ill acts as a reward and may prolong recovery. Awareness of motivational differences, such as the relationship between wellness versus education based upon Maslow's hierarchy of needs (1970) might also help parents to understand the psychological mechanisms behind their child's behaviour or willingness to continue with educational tasks.

Parents may feel overwhelmed or isolated by having a sick child within the family and EPs could also offer practical help in linking families with appropriate support groups or charity organisations in order to help negate these particular feelings. Psychologists may also help families in developing a picture of how siblings might be expected to react to having an ill brother or sister. Providing information to the family based upon research may help siblings to feel supported and parents to feel empowered by this information. The literature on this subject recommends that siblings are involved, not excluded from the sick child's treatments (Curnick 1990), although as there is little evidence to support the benefits of this approach, this must be a decision that is made by the family, based upon the maturity, understanding and willingness of the child to engage in this way.

## **Support to schools**

### **Reintegration**

Within the Access to Education document (DfES 2001), it is described how EPs might play a useful role as part of the reintegration process as part of a statutory assessment of the pupils needs. Psychological literature indicates however that the issues affecting children and young people with medical needs are highly relevant to Educational Psychology (Williams, 2002). EPs undoubtedly have a wide and creative role in supporting the integration of pupils back into school following an absence due to medical needs as well as supporting schools within a broader context. One such issue is in highlighting possible barriers to reintegration for school staff in order that a problem-solving model might be applied to support the individual pupil's needs.

### **Working with school staff**

School staff may have particular anxieties about meeting the needs of a pupil with a particular medical need, particularly if this relates to a mental health condition. The educational psychologist is well placed to reassure school staff that the child's needs have not changed as a result of a medical label that might be alarming to some school staff. Through the consultation process, EPs are able to discuss concerns and management issues for pupils with medical labels, for example on behaviour management for a pupil with a diagnosis of a conduct or hyperactivity disorder.

Staff in schools may express some anxieties that the pupil's needs cannot be met within the schools resources following a diagnosis of a particular medical condition. As with all pupils who might be considered as having special educational needs, psychologists can encourage schools to consider the pupil's needs and responses to intervention through precise target setting and measurement of progress and to encourage staff to view the access to education for all children as a human rights issue.

Where a child with a life threatening or terminal illness is on role, staff may look to the psychology service for guidance in relation to how to prepare pupils in coping with bereavement and loss and to highlight how this might also impact upon teaching staff. Educational psychologists have considerable experience of working in this area through supporting young people who have experienced loss and involvement in critical incidents in schools.

With knowledge of working with children, parents and staff, psychologists are able to gain information from pupils in relation to their understanding of how medication and side effects are impacting upon their learning as well as how being in pain might affect attention levels and their approach to a variety of tasks. Other factors, such as tiredness and lack of sleep might also impact upon a pupil's learning and therefore it is necessary that staff are aware of setting tasks that are manageable for the pupil in terms of their

illness and how it affects their performance. Health should be viewed as a continuum, with staff being prepared for pupils within their classes having a range of medical needs that may have some bearing on their education (Weare 2000). Staff may feel relatively comfortable in knowing that a child with diabetes or asthma is in their class where appropriate medical personnel manage the condition. If the illness is more unusual or severe however, they may feel less confident about dealing with situations within the class that occur as a result of this illness. Teachers may feel particularly concerned about being asked to provide an appropriate curriculum for a sick child whose ability to access the curriculum depends on their physical or mental health that varies from day to day.

Literature from the 'Young Minds' charity which works with children and young people who are experiencing mental health difficulties, states that teachers should not feel deskilled if they require help to support a child within the classroom and cite the Educational Psychology Service as an agency with a key role in supporting teachers in meeting the needs of pupils who have mental health needs. By being supported in this way, teachers may feel more confident in working with pupils who have mental health needs, as research indicates that this is an area which can cause anxiety for them (Atkinson and Hornby, 2002).

## **Social inclusion**

**Another important area in which psychologists are able to support schools in the reintegration of pupils with medical needs is in the social inclusion of pupils. Children with medical needs may feel different to their peers and friendships may have suffered through prolonged hospitalisation or managed illness within the family home. Some children may suffer bullying and rejection by their peers, particularly if their appearance has changed due to medication and it is important for families and schools to develop a more positive self image within the child and to build self esteem through providing success within the school system. Children returning to school after a long period of illness may also have physiological differences to their peers, such as the need for regular medication or a restricted diet. These are additional factors that might encourage the sick pupil to feel different and it is important to address these issues within the social group. Work on social integration where there has been a long absence may also involve specific involvement with the young person and their peers, for example through social skills groups and specific strategies such as Circle of Friends.**

**Consultation relating to specific issues such as group dynamics might be helpful to school staff as would modifications within the physical environment that may help to alleviate some pupils anxieties, such as providing privacy for taking medication away from the busy 'medical room' which is often a multi-purpose area. Specialist staff may be available within**

the Local Education Authority to advise staff on how to support pupils with particular physical needs, such as advising upon wheelchair access within the school, and whether pupils have access to appropriate toileting and washing facilities. Staff may need to be made aware of such specialist resources within the county and multi-professional working can be supported and encouraged by the educational psychologist.

### **Setting boundaries**

The teacher's feelings of empathy or pity towards the sick child may make it difficult to respond objectively to disruptive behaviours, although Fithian (1984) argues for teacher objectivity and impartiality and states that emotional and behavioural difficulties in class create the same degree of disruption in the class, no matter what the route cause. This type of discussion is one that EPS may usefully conduct with teachers in order to consider the school's response to pupils with behaviour difficulties that also allow individual teachers to feel comfortable and supported in their disciplining role with the sick child.

### **Support to the Local Education Authority (LEA)**

#### **Gaining evidence**

The Access to Education document (DfES, 2001) suggests that providing medical evidence for pupils to gain access to educational support can be an important issue for LEAs. Educational Psychologists have a role in gathering this evidence, perhaps through sharing records of behavioural

observations with medical staff, and considering the response of individual pupils to interventions that have been implemented within the school setting, such as anxiety control, anger management, or cognitive behavioural therapy approaches. In gaining evidence about the child's learning needs, information relating to their learning characteristics, environment, task, and teaching style must all be taken into account.

#### **Liaison with the Home Tuition Service**

From meeting with home tuition co-ordinators within a Midshire County, it appeared that a stronger link with the EPS would be welcomed, to provide the level of support that is recommended within this assignment. It was also suggested that EPs may have a role in highlighting pupils who are not attending school due to medical factors, who are not known to the Home Tuition Service. These are often vulnerable pupils with mental health needs, such as pupils experiencing anxiety or depression. Pupils with psychological or mental health needs were described as falling within a 'grey area' in terms of support and therefore it was felt that liaison between the EPS, home Tuition Service and other agencies may help stop children falling through the net of provision. In addition, home tuition staff felt that the EPS might support them in terms of staff training, for example in working with pupils who have SEN needs in addition to their medical needs, child assessment, reintegration, multiagency work, raising awareness amongst professionals, work with parents and, where appropriate, a therapeutic role.

Following consultation with the home tuition staff, it was agreed that the following services might be added to the possible 'menu' of support:

- Identifying gaps in education through attendance issues
- Identifying changes in the individual following illness or medical intervention, for example a change in cognition following a psychotic episode
- Planning and implementing interventions
- Providing strategies for home-teaching staff
- Considering realistic long and short term goals for the pupil
- Advising upon the child's educational needs and how this might relate to provision
- Family work
- Involvement in transition plans to increase independence and confidence

This added support to the EPs view that a creative input would be welcomed from their service in supporting young people with medical needs.

### Support to other professionals

Educational Psychologists can provide a valuable role in supporting health professionals by drawing upon their knowledge and experience of developmental psychology. Through training and consultation, an awareness of how a child's understanding of the concept of illness differs

according to age, cognitive development and early experiences might be promoted. Other issues could also be raised for discussion, such as how separation from caregivers, for example through hospitalisation, might affect a child's emotional response to the illness and also how professional healthcare workers might reduce childhood stress created by an illness.

Some families of sick children report a feeling of a lack of control over their lives due to the amount of appointments that they are obliged to attend (Stein and Wooley 1990) and therefore this has implications for the level of intervention and support that families might be willing to engage in from the EPS. It is generally agreed that agencies need to be able to work in a flexible way to provide continuity for the child, however Jeffrey (1990) describes the, "undue formality" of linking services together can mean that procedures move too slowly to adapt to the young person's changing medical and educational needs. This perspective emphasises the necessity for educational psychology services to prioritise support to children with medical needs over other areas of their work in order to provide a responsive service to this vulnerable cohort of pupils.

## **Conclusion**

This assignment argues that many of the issues faced by children with medical needs are relevant to educational psychologists (EPs) and that EPs have a unique role in understanding and supporting this group of young people. There is a clear, creative role for educational psychologists working in this area and this should be considered as being more wide reaching than a purely statutory function.

In terms of offering individual support to the young person, educational psychologists might help individuals in understanding their illness, establishing children's views and providing interventions to help meet their emotional needs. Systemic approaches to supporting the children could also be offered by EPs in terms of working with families, schools, the LEA and other professionals. It is also clear from considering the literature that more research-based evidence is required in this area, and this is another role in which EPs could play an important role.

It is necessary for Educational Psychology Services to adopt flexible working patterns to allow for EP involvement with sick children, as effective liaison with other agencies are an integral part of this work. The role of the EP in supporting children and young people with medical needs should be prioritised within EP Services in order to meet the needs of this vulnerable group of young people.

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# **APPENDIX ONE: MIDSHIRE POLICY FOR ACCESS TO EDUCATION FOR PUPILS WITH MEDICAL NEEDS**

## **MIDSHIRE COUNTY COUNCIL SPECIAL EDUCATIONAL SERVICES HOME TUITION AND HOSPITAL TEACHING SERVICE**

### **Policy for Access to Education for Pupils with Medical Needs [2003]**

#### **1.0 Introduction**

Local Education Authorities have a duty to make arrangements for the provision of suitable full-time or part-time education otherwise than at school for pupils of compulsory school age who, for reasons of illness, may not for any period receive suitable education unless such arrangements are made for them. (*Education Act 1996*)

A similar duty applies for young people aged 16-19 (*Access to Education for Children and Young People with Medical Needs 2001*).

Responding to current DfES Guidance and Best Practice, Midshire's policy for Access to Education for Pupils with Medical Needs aims to promote inclusion by:

- Ensuring access to suitable education for pupils whose medical needs cause them to be out of school;
- Promoting continuity of education, minimising disruption to the pupil's education during periods out of school;
- Providing suitable education which is relevant and meaningful for the child, enhancing the life chances of pupils whose access to the curriculum is restricted by illness or medical condition;
- Supporting the timely return and reintegration to school of pupils, in accordance with their medical status.

For the purpose of this Policy, Pupils with Medical Needs are defined as:

- Pupils who are physically ill, injured or recovering from medical interventions.
- Pupils with mental health problems.
- Pre- and Post-natal pupils who are unable to access education in schools

## **2.0 Standards**

Whenever pupils are referred to Midshire's Home Tuition and Hospital Teaching Service, evidence will be sought to support the provision of Education Other Than at School. In particular, the Service will wish to establish whether pupils are able to continue to receive some or all of their education at school. This may apply in particular to pupils with mental health needs, in whose case collaboration will be sought with colleagues in Child and Adolescent Mental Health Services.

In every case, contact will be made with the home school through the designated teacher. Information will be requested, in particular, the pupil's level of attainment within the core subjects of the National Curriculum. Additionally, evidence of progress from standardised tests, or from Individual Education Plans in the case of pupils with Special Educational Needs, will contribute to the planning process. School staff will work in partnership with the pupil, the Home and Hospital staff and parents, and will make available to Home and Hospital tutors information such as curriculum and lesson plans as well as materials to enable continuity in education provision.

Medical evidence will be sought to establish the amount, pattern and location of tuition provided as well as to plan pupil reintegration at school. Home and Hospital Teaching Service staff will initiate contact and liaise closely with the pupils, their families, their schools and other services as appropriate, including Social Services, Health, the Education Welfare Service, Connexions and with the Educational Psychologists providing a dedicated service to Pupils with Medical Needs.

Pupils will receive an education of similar quality to that available to pupils in schools, including abroad and balanced curriculum. The statutory entitlement of 10 hours teaching per week will be made available, with additional time provided where appropriate, for example, where the pupil is preparing for public examinations. Progress will be monitored closely and reviewed and reported half-termly.

As appropriate, arrangements will be made for pupils to undertake national tests and examinations.

The LEA accepts responsibility for ensuring that pupils with identified medical needs, who are out of school, receive access to Education within 16 working days of a referral being made, and that pupils with long-term or recurring illness have access, as far as possible, from day one.

## **3.0 Referrals**

### ***Home Tuition***

- All referrals for tuition at home will be sent to the local Area Home and Hospital Teaching Service Coordinator using the appropriate proforma [Appendix A].
- Referral forms should be completed by the home school's designated teacher.

- All referrals must have supporting medical evidence of the need for Home Tuition. This will be provided by an appropriate medical practitioner who will be a Community Paediatrician or a Hospital Consultant. General Practitioners cannot authorise requests for home tuition.
- Unless the pupil has a long-term or recurring medical condition, a pupil out of school will not qualify for Home Tuition unless they are likely to be out of school for more than 15 working days.
- In accordance with Statutory Guidance, the minimum entitlement to teaching is 10 hours during term time only. Flexibility is allowed when taking into account any medical condition.
- Medical evidence should be supplied on a termly basis to support the continuing provision of Home Tuition.

### ***Hospital Tuition***

- All referrals for Hospital Tuition will be made by the relevant Hospital Consultant through designated medical staff.
- Educational provision will commence as soon as practicable after the child's hospital admission.
- The Home and Hospital Tuition Service will oversee the arrangements made for the reintegration of pupils at their school following their absence through illness, whether this is within County or elsewhere, as in the case of pupils who are the responsibility of other LEAs.

### **4.0 School Responsibilities**

All schools must have a written policy and procedures for dealing with the education of children and young people with medical needs. This may stand alone, or be incorporated into the school policy on Special Educational Needs.

Each school must designate a named member of staff to be responsible for dealing with pupils who are unable to attend school because of medical needs. Where a pupil is known to have potentially long-term sickness or recurrent bouts of chronic sickness involving periods of absence, the designated teacher should contact the School Doctor in order to discuss the management of continuing education, including referral to the Home and Hospital Teaching Service. Through regular communication and forward planning, unnecessary gaps in education can be avoided. The designated teacher will take responsibility for supplying the Home and Hospital Teaching Service with information about the pupil's capabilities, progress and programme of work. The school will be active in the monitoring of progress during absence from school, in liaising with other agencies and in the pupil's reintegration.

In cases of unpredictable, acute episodes of illness resulting in absences from school of more than 15 days, the designated teacher should liaise with the School

Doctor as soon as possible to establish whether referral to the Home and Hospital Tuition Service is appropriate. Such cases of absence from school which last more than 15 days should be investigated and reported to the School Doctor. Close collaboration with the Education Welfare Service is essential in establishing the status of the absence.

In every case, the designated teacher needs to inform parents and carers that other professionals are being consulted about their child's absence from school.

Schools will ensure that pupils, absent from school because of medical needs, are kept informed about school social events and that they are able to participate as fully as possible in the life of the school, for example in homework clubs, study support, liaising with peers through visits and videos.

In particular, it is expected that schools will

- Liaise with the Home and Hospital Teaching Service, in particular providing up-to-date information about records of achievement and curriculum promptly.
- Consider the need for assessment under the SEN Code of Practice (Pupils with a Medical Need).
- Ensure that suitable programmes of work are available to pupils receiving Home Tuition/Hospital Teaching, that these are consistent with what the pupil would normally be studying whilst at school and that they take account of the pupil's views.
- Provide appropriate resource material where possible
- Meet all examination fees on behalf of the pupil
- Make arrangements for 11-plus, SATs, GCSE, A/AS levels and any other examinations/accreditation.
- Assess coursework.
- Maintain contact with the pupil and their family.
- Take part in planning and review meetings, especially those called to organise reintegration at school.

## **5.0 LEA Responsibilities**

The LEA holds responsibility for ensuring that pupils with medical needs are able to access suitable education. This includes developing and implementing policy which secures individual entitlement. The key to successful implementation is partnership and the LEA holds the central role in initiating, developing and

**sustaining those partnerships which are necessary to provide suitable, high quality education to pupils with medical needs.**

**Collaboration at a senior level between the County Council's Children and Young People's Portfolio, Health and schools will be promoted via the SEN Strategy Group. A named, senior Officer within the Children and Young People's Portfolio holds responsibility for the provision of education to children and young people who are unable to attend school because of medical needs. This officer is x, Education Manager, County Hall.**

**In particular, the LEA will ensure that:**

- This policy is readily available and widely publicised.**
- Every pupil, who is unable to attend school because of a long-term or recurring medical condition, has a personal education plan. This should take effect as soon as a pupil is admitted to hospital or is unable to attend school. Education should begin as soon as the medical condition allows.**
- Pupils absent from school for medical reasons receive suitable education by the sixteenth day following referral.**
- Pupils whose diagnosed medical condition indicates prolonged or recurring absence from school have access to education from day one of each absence where possible.**
- 10 hours teaching each week of term is provided as a minimum entitlement, ensuring that planning is appropriately informed by medical advice and that the pupil can cope with the educational programme offered.**
- A broad, balanced and suitable curriculum is delivered.**
- Half-termly reports on pupil progress are provided in writing to the pupil, to parents and to the school.**
- Multi-agency/multi-disciplinary working is promoted, with clear lines of communication, in particular ensuring appropriate liaison with medical professionals, including where appropriate Child and Adolescent Mental Health staff, relevant staff in the pupil's school, education welfare officers, educational psychologists and any other involved professional parties.**
- Continuity in education is supported, including promoting access to home school activities and events.**
- An individually tailored reintegration plan which meets with multi-agency approval is in place before the pupil returns to school.**
- Educational support continues to be provided by the Home and Hospital Teaching Service in those cases where reintegration is gradual and part-time.**

- Home and Hospital Teaching Service staff receive appropriate professional support via in-service training and performance management in order to sustain the quality of teaching and learning.
- The Home and Hospital Teaching Service is monitored and reviewed to ensure that the needs of pupils are met, that the service is cost-effective and that all relevant statutory requirements and guidance is adhered to.
- Appropriate information on the Home and Hospital Teaching Service is available.

## **6.0 Midshire Home and Hospital Teaching Service**

*Service Coordinator Schoolroom:*

*(address removed)*

It is a requirement of the service that at least one other adult nominated by the parent/hospital staff is available on the premises during home/hospital tuition, i.e. the home tutor is not the only adult on the premises during tuition.

Other premises may be used for home tuition, for example school premises, other County Council Health Service premises. The additional available adult principle applies in each case. Locations within the hospital other than the designated schoolroom may be used for hospital tuition.

All general enquiries regarding the Home and Hospital Teaching Service should be referred to the local Service Coordinator in the first place.

Issues concerning quality of service, including complaints, should be directed to x, Education Manager.

The assigned educational psychologists can be contacted at (y)

## **APPENDIX TWO: Case study; Jennifer**

The following case study provides an anonymous, but 'real world' example of how the EPS was able to support a pupil with complex medical needs by providing a wide range of support within some of the contexts that have been previously mentioned.

### Context

In February 2002, Jennifer, then aged 9, was involved in a road traffic accident that left her with severe head injuries from which she was not expected to survive. After a period of several months in hospital, she was moved to a rehabilitation centre, away from her home area, for a range of treatments and therapies.

The LEA initially became aware of Jennifer's needs when her parents wrote to request that a Statutory Assessment of her needs be made under the 1996 Education Act. The LEA had not previously been alerted to the fact that Jennifer had medical needs that would prevent her from receiving education for longer than 15 days because she had not attended an LEA school. Jennifer's family ran their own business, which meant that they had to travel throughout the country and therefore her mother, monitored by the Educational Welfare Service, had educated her. This was an unusual situation because it meant that the LEA was not informed about Jessica because she had been educated at home, she was placed in a London

hospital and then a rehabilitation centre. The LEA were unaware of what had occurred and Jennifer was therefore a child who had appeared to 'slip through the net' of provision.

From the evidence given to the LEA by Jennifer's parents, it was decided that the LEA would proceed with a Statutory Assessment of her needs. Having been recently appointed the EP representative for pupils with medical needs, and being the EP with schools in Jennifer's 'home' area, the Author was asked to complete the Psychological Advice to the LEA.

From the time that the Statutory Advice was requested, a number of issues became apparent for the EPS, which are summarised hereafter:

- The Statutory Advice did not have to be completed within the usual timescales as Jennifer was placed in a rehabilitation centre, which was not in the LEA, a legitimate reason for the Formal Assessment timeline to be delayed (DfES 2001). The EP therefore had to decide whether to undertake an assessment of Jennifer's needs to provide Psychological Advice to the LEA as a matter of urgency, or whether to await Jennifer's return to the LEA, which was not expected for several months. It was decided that Jennifer and her parents should be visited at the rehabilitation centre and that the Psychological Advice should be completed in order to gain a detailed picture of Jennifer's needs and to pre-empt any delays in finding a suitably supported school placement for her in the future.

- With the majority of EP time being delegated to schools and preschoolers, there was no flexibility within the system for a visit to a pupil who did not have a school, having previously been educated at home. Time to visit Jennifer on an out-county basis and to write the Psychological Advice therefore had to be taken from other aspects of the EP's workload, such as time for CPD and administration.

- Jennifer was still in the early stages of recovery and it was unclear as to what her special educational needs would be, long term. This made it difficult to write the Psychological Advice to the LEA in terms of commenting upon Jennifer's long term needs and objectives.

- Jennifer had some specific areas of cognition that were affected by the accident, including aspects of language, reasoning and memory, whilst other areas remained intact. This gave rise to particular issues about the type of provision that was thought to best meet Jennifer's complex needs.

- Jennifer was still suffering some emotional trauma as a result of the accident and when the subject of the accident or aspects of her 'previous life' were raised that made her feel uncomfortable, Jennifer's behaviour became challenging and this had implications for her future schooling.

• Jennifer was described by her parents as being an unusual child in terms of her social skills before the accident. She was their only child and took an active part in her parent's business and was consequently more confident in dealing with adults and unfamiliar people than most pupils within her year 5 age group. This was difficult to quantify as Jessica had experienced such a transient lifestyle and there were no school records or staff to provide an objective view. Following the accident, Jennifer's difficulties with socialisation were easily observed. In public she would make socially inappropriate comments without realising their impact upon their audience and therefore it was clear that educational provision for Jennifer would have to consider her complex social, emotional and behavioural needs alongside her physical, medical and cognitive skills.

• Another important issue was in considering how Jennifer might be integrated into school. Jennifer's mother felt that she could no longer educate her at home and had been thinking that at secondary transfer that it would be more appropriate for Jennifer to be within an environment in which she could develop a regular teenage peer group and have access to more specialised technology, curriculum equipment and teaching expertise.

• The Senior Officer who had been involved with Jennifer's case was seconded to another role and nobody within the LEA was therefore providing an ongoing link for Jennifer's parents at a time when they needed

continuity. More than twenty professionals from different disciplines were involved in working with Jennifer and the Educational Psychologist therefore provided this key role of support to her parents.

#### How the EPS was able to support Jennifer

- Liaising with other agencies
- Undertaking observation and assessment activities
- Commenting upon her needs and considering these against schools that could receive and support her.
- Discussing Jessica's needs with a link primary school who was willing have Jennifer to visit the school during the Spring and Summer terms of Year 6 under a restricted access scheme in order to help her to develop some peer relationships with pupils who would also be transferring to secondary school to promote her social inclusion
- Supporting Jennifer's parents through the Statutory Assessment process
- Raising possible questions about how she might best be supported in school
- Monitoring her psychological and educational progress
- Raising questions to the LEA about how she was to be supported through the transition to school, particularly as with the change in personnel within the LEA there was a risk that Jennifer might again fall through the net of provision.

- Unusually, it was the Educational Psychologist who alerted the home tuition service to Jennifer's needs

Following the completion of the Formal Assessment process, Jennifer's parents decided to educate her in an independent school that was not within the LEA, the cost of which they met from within their own resources. Jennifer's parents stated that they had welcomed the support that they had been offered by the EPS at a time that was stressful and challenging for them. Her progress will be monitored by the LEA and the EP from within the Midshire County who has close 'out county' links with the school that Jennifer now attends, has been alerted to her case.

**ASSIGNMENT FOUR:**

**ONE SIZE FITS ALL?**

**USING THE 360 DEGREE FEEDBACK APPROACH  
AS A METHOD OF MEASURING INTERPERSONAL  
EFFECTIVENESS**

## One Size Fits All?

### Using the 360 Degree Feedback Approach as a Method of Measuring Interpersonal Effectiveness.

#### **Introduction**

In January 2000, I started the Doctorate in Educational Psychology Course at University College London, a programme that continues to date. This period of time has represented a metamorphic period of my life, in which I have experienced significant changes in both my professional role and in my personal life. This fourth assignment has allowed me the opportunity to reflect upon the process of change within the past four years and to consider my professional development and personal growth within this time period.

In measuring my interpersonal effectiveness within a work context, I have used the 360-degree feedback tool to reflect upon my performance and will consider the strengths and weaknesses of this approach in measuring individual performance. In addition, I have considered the importance of effective CPD for individuals operating within an organisation and have related this to both my employer's LEA model for CPD and how this might relate to the British Psychological Society Guidelines for professional development.

**My objectives for this assignment are therefore as follows:**

- **To consider the current context of education and educational psychology and how this might affect the continuing need for educational psychologists to have access to high quality CPD experiences**
- **To consider my professional and personal development over time and to reflect upon the factors that have impacted upon this development**
- **To consider the changing model of CPD from within the County Council in which I am employed and the impact of this model upon personnel**
- **To consider the British Psychological Society's perspective on CPD**
- **To consider the effectiveness of 360 degree feedback as a mechanism for CPD**
- **To consider ways forward for EPSs and LEAs in terms of the development of models of CPD**

## **Context and Practice**

The current context of education and educational psychology

Within the past decade there have been pressures upon Government at a local and national level to prioritise 'Education, Education, Education' following periods of rapid reform in the 1960's and 1970's and one of relative consistency within the 1980's (Altrichter and Elliot, 2000). The improvement of teacher effectiveness is placed at the heart of educational policies with the development of occupational standards, evidence based practice and performance related pay (Reeves et al 2002). More prescriptive teaching methods have reportedly decreased the intrinsic motivation and job satisfaction for teachers whilst stress levels are reportedly increasing within the profession (Fullan, 2003).

This recent phase within educational history has linked closely to changes in culture within society, however it is argued that the effect of economic productivity within the country also contributes to the educational climate (House, 2000). Schools are increasingly being encouraged to adopt responsibility for the management of their own budgets and to provide services that promote high productivity at reduced costs, therefore applying a business-like approach to managing their needs. This has placed additional stresses upon head teachers and school managers who may not have previously been exposed to corporate structures and systems. Whilst it is not disputed that schools should provide high quality services and value

for money, there is considerable concern that the concepts and imagery of commerce are also being applied to the results achieved by children within schools. Within today's educational system, school performance is measured largely in terms of the league tables that are widely reported within the press. Schools therefore feel under pressure to promote the academic aspects of school life in order to be perceived as being successful whilst other areas of education, particularly the inclusion of pupils with special educational needs, are sometimes viewed by school staff to conflict with the market-place philosophy.

Another source of pressure for schools are parents who, following the 1980 Education Act gained the right to express a preference of school for their child's education, which established a need for schools to become more competitive and attractive to families. Schools are now more accountable for their actions and within this climate of change threats of litigation from parents are also becoming a source of anxiety for schools (Chitty and Dunford, 1999). For educational psychologists who are committed to encouraging schools and parents to work in partnership with other agencies, this is perceived to be a source of conflict. In practice an important aspect of the educational psychologist's work is in promoting positive and trusting relationships between parents and professionals, and as a consequence of this, reducing the opportunities for conflict between these parties.

With finances being increasingly delegated to schools, it is perhaps not surprising that the role of support staff is also changing within Local Authorities. Since the budget for the Learning Support Service was delegated to schools within my employers LEA, schools now have the opportunity to 'buy back' LEA retained staff or to seek alternative support from independent teachers or organisations. During the period in which these changes have occurred, LEA staff have expressed mixed views in relation to how they were adapting to this situation. Upon reflection, the role of support teachers appears to have changed particularly for those individuals who are employed independently of the LEA who often present a 'within-child' model of assessment-based practice. Considerable variation has been identified in terms of the opportunities for EPs to liaise with support teachers in relation to individual pupils, depending on whether schools are willing to finance this time as part of the teacher's assessment process. As a result of 'Best Value' reviews, it is possible that the process of financial delegation to schools will be further extended and that schools will therefore be required to purchase the services of educational psychologists from within their budgets. The effect of this proposal upon the work of EPs can only be speculated upon. If the experiences of the support teachers from within my LEA are an indication of how schools wish to utilise the skills of individuals from outside agencies, it is anticipated that the role of the EP would become narrower as a result of this action.

The need for high quality professional development for educational psychologists working within LEAs is particularly pertinent within this metamorphic period as EPs are well equipped to support schools and LEA staff through the process of change. The significance of CPD opportunities for EPs is also important in terms of gaining new skills and competencies and this was emphasised within the DFEE paper; "Educational Psychology Services: Current Role, Good Practice and Future Directions" (DFEE, 2000). This document highlighted the need for EPs to have access to appropriate training and development opportunities in order to extend professional knowledge and experiences. Consideration as to how this issue has been approached from both the BPS and from within my employer's LEA will be explored further within this assignment.

#### **My perceived role within the LEA**

After qualifying as an Educational Psychologist in 1996, I worked as a maingrade EP for two years within a London Borough before moving to a Midshire County EPS where I have remained to date. Whilst employed within this Authority, I have experienced a considerable amount of change at both an organisational and professional level. Within the Council Context, there has been extensive restructuring, which has impacted upon the way that the Education Department has been managed at a County level. This rapid pace of change has also been reflected in the EPS, which now has the fifth Chief/Principal EP since I joined the service in 1998. These substantial changes, in addition to the terms of pay and conditions which

are peculiar to my employer's LEA where educational psychologists are not paid on the Soulbury Scale, led to a rapid turnover of staff, particularly within the January to September 2002 period.

It was at this time I was appointed to an Acting Senior EP position to cover a colleague's maternity leave. This coincided with an enormously challenging and stressful period for the service that saw a reduction in the number of maingrade colleagues, until staffing fell to a 50% level. In consequence, the EPS were forced to offer a service that conflicted with their philosophy of being proactive in working with schools and reduced the opportunities for offering consultation and assessment of children's needs over time. 'Emergency cover' was offered to more than forty schools within the LEA, which comprised responding to requests from the LEA for statutory assessments, involvement with transition reviews and work with preschool children. Working within a reactive way created conflict for many psychologists within the service and contributed to feelings of anxiety and low morale.

This situation has improved through a greater stability in the management structure of the EPS and a recent agreement in relation to pay and conditions, however EPs within the service continue to be faced with new challenges within the coming academic year as further restructuring within the Council is planned. This will involve closer links and integrated services between Education, Social Care and Health Professionals and the

possibility of EPs being separated from EP colleagues and placed in multidisciplinary teams has been mooted. Not unnaturally, such proposals have done little to reduce anxiety within the service staff.

In terms of my own professional development, working as an Acting SEP within a period of crisis within the EPS has provided me with many opportunities to explore my own strengths and weaknesses. My role comprised (a) the line management of colleagues (b) the organisation of the work rota that was developed for 25 of the schools within my geographical area which had no EP cover during the time of 'crisis' and (c) responding to the compliments and complaints received from schools. A major concern was that morale was extremely low within the EPS and yet because of the time involved in covering work with such a limited number of personnel, there appeared to be no time slots within which to consider how to support the team throughout this difficult period.

After my Acting SEP role ended in August 2002, I resumed work as a maingrade EP and was then appointed to a permanent SEP position that started in September 2003. This permanent senior post represents an exciting new challenge and it is anticipated that this will provide an opportunity to utilise the skills that I developed as an Acting SEP, combined with my experience and the knowledge that I have developed as part of my DEdPsy course. Since I am aware that individuals within the EPS team report through supervision sessions that they continue to feel vulnerable

about the difficulties that were experienced last year, part of the challenge of the new role will therefore be to consider how confidence and security can be fostered within the team. I will also have responsibility for promoting Inclusion within the Authority, an enormous challenge within an Authority that operates a selective secondary school system!

Whilst there has been a rapid pace of change within my professional life, my personal life has also altered significantly since I embarked upon the UCL Doctorate course. During the past four years I have become a parent, juggled the demands of working full time with motherhood, and later coped with becoming a single parent following separation from my husband. Towards the end of 2000, I was diagnosed with a chronic, life-long medical condition called Graves' Disease, which affects my immune system and in particular my thyroid gland. The treatment for this condition requires daily medication and frequent hospital reviews until the optimum levels of medication to suit my needs are identified. As a consequence of the condition and medication, I am aware that there have been changes in my personality, performance and ability to access some of the opportunities that have been presented to me.

I believe that it is the powerful combination of professional and personal factors that have impacted upon my interpersonal effectiveness within the past four years and I have relished in the opportunity to reflect upon these factors in a structured and formal way within this assignment. In confronting

the challenges that I have experienced within this time period, I believe that I have gained in my knowledge and skills. As educational psychologists, we spend considerable time observing and interpreting the working patterns, motivating factors, progress and learning styles of others and yet it can sometimes seem that there is little opportunity for this activity in terms of personal reflection. One technique for encouraging self-reflection through feedback from oneself and others is the 360-degree approach, which I have used as a mechanism for considering my own development over the past four years.

#### *360 degree feedback*

I was first introduced to 360-degree feedback (hereafter known as '360') as a means of considering individual performance in 1998 when I joined my current EPS. At this time, 360 was being piloted within the service, alongside other mechanisms for appraisal and supervision that were linked to the County model of Performance Management. At this time, it was anticipated that 360 could be formally adopted within the EPS and could then be promoted to other services. This was not to be the case however, largely due to changes of management personnel and leadership style within the service rather than a lack of support for the approach itself. As I had joined the service after the first phase of the 360-degree implementation, I was not part of this initial phase and therefore my first 360 experience was in 2000 as part of my Doctorate in Educational Psychology programme.

Within the EPS, 360 is now enjoying a revival. This feedback model is to be gradually implemented, and the first phase, involving feedback to the Principal and Senior EPs, will be completed by August 2003. It is anticipated that maingrade EPs take part in this process over the next academic year, although it is still not clear as to how this will link to the supervision and appraisal systems that are established within the Council framework.

The 360-feedback tool is a useful mechanism for exploring how individuals perceive themselves against a range of statements relating to selected key aspects of their professional knowledge and skills, and also how others, such as colleagues or clients, perceive them against the same criteria. The approach uses a questionnaire format to elicit these views and respondents are required to make judgements in terms of both how important each of the items is to the work of an EP and also how well they perceive the rated individual to perform against a particular statement. Some of the benefits and also the disadvantages of this approach are discussed within the 'Research' section of this assignment. It is anticipated that, with 360 being developed as an assessment tool for EPs in the LEA, that the information held within this assignment will be of benefit for colleagues within the service when considering how this approach could be implemented and utilised within the service. While 360 is certainly a useful mechanism for encouraging self reflection, the effectiveness of this tool should be placed

firmly within a context in order that issues of bias, validity and reliability are considered in the interpretation of the results. These issues will be considered further within this assignment.

## **Review of the Literature**

The opportunity for managers to reflect upon the strengths and weaknesses of individuals within their team is regarded as being key to the team's success (c.f. Belbin 1981). Such information would include 'general' team characteristics, such as the size and structure of the team, but also more specifically how optimum interpersonal effectiveness can be achieved, both for the benefit of individuals and the team as a whole.

Research in this area is not new, for example McGregor (1960) suggested there to be many factors that are significant in promoting organisational effectiveness including the effect of different management and leadership styles upon team performance and the representative characteristics of effective teams. Following this period of early research, the zeitgeist within organisations began to change from considering organisational effectiveness as being based purely on skills and attainments, to considering the potential of individuals and the quality of the communication processes within teams. It was within this climate that the concept of the Johari window was developed; this is a framework that allows individuals to explore aspects of their own behaviours through gaining information that may not be obvious to them. The four 'panes' of the window are described as follows:

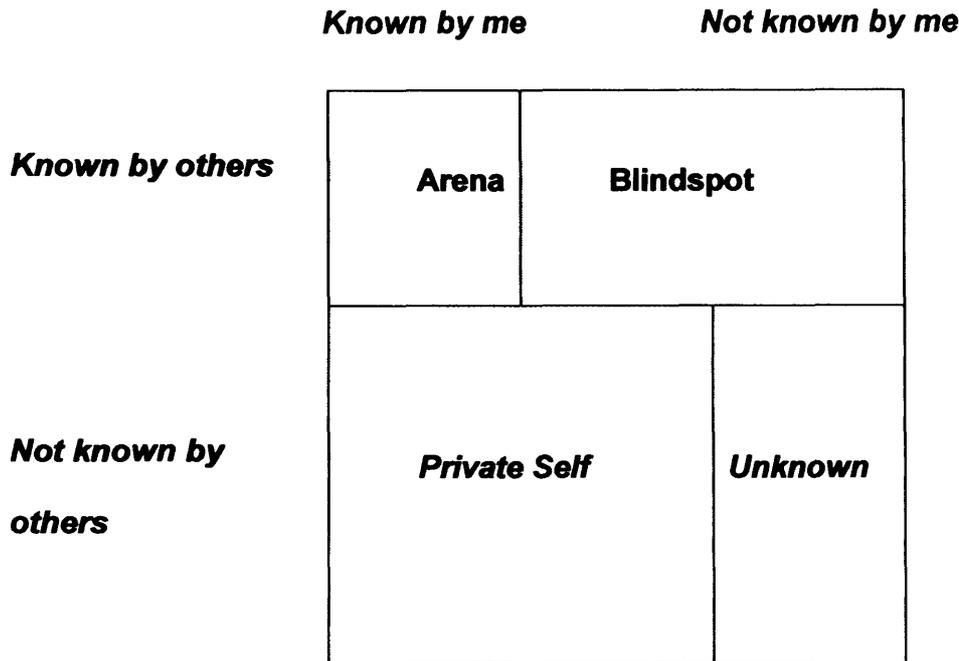
1. The *Arena* is the area of public knowledge that is known by the self and others, such as a job title.
2. The *Blindspot* relates to information that is not known by the self, but is known by others. This may relate to aspects of an individual's professional skills or competencies that have not been communicated to them.
3. The *Private Self* describes the information that an individual chooses not to share with other members of the group, such as worries or prejudices.
4. The *Unknown* area describes aspects of the individual that are not yet known by the self or others, and could relate to an individual's potential.

The dimensions of the four panes of the Johari window are not the same for each individual, or for each team. When an individual first joins a team, the dimensions of their 'Private Self' pane is likely to be larger than the others because they are unlikely to disclose personal and professional details about themselves until they are sure that they are within a trusted environment, as in Figure One overleaf (Insight Management Solutions Course 1991). Over time however, the dimensions of the panes will change until there is more information within the 'Arena'. This is because more information about the individual will be known to a wider range of people.

The 360-degree feedback approach is able to consider some of the 'hidden' areas of the Johari window and place them in the 'Arena'. This may include aspects of the 'Private Self' being identified through self-reporting and

aspects of the 'Unknown' being recorded by others in their responses about an individual.

**Figure One:**



This level of disclosure may create anxieties for some individuals who might feel concerned that their vulnerabilities are being highlighted by the 360 process. This is particularly true where appraisals and performance-related pay are linked to 360. This raises issues as to whether individuals should have to provide consent before undertaking such an exercise within an organisation. There are also other ethical considerations in using 360 as a method of measuring professional skills and competencies. It is essential that the individual who is undertaking the 360 degree experience is clear

about who the feedback will be communicated to, as well as understanding the status of 360 within the Performance Management structures that may exist within the workplace. It is important that having been given this information, individuals should be given the right to withdraw from the process.

How useful is 360-degree feedback as a mechanism for measuring interpersonal effectiveness?

#### Strengths of the 360 degree approach

The 360-degree feedback approach provides a picture of an individual's professional strengths and weaknesses in terms of their professional knowledge and skills. The statements contained within the 360 questionnaires are highly relevant to the professional role that is undertaken by the individual, as the questions are specific to their particular job. The questions for educational psychology services were developed using information from research, professional bodies, focus groups, and service guidelines and these were then considered using a meta-analysis approach to elicit core aspects of the professional role that condensed the questionnaire into four sections; Interpersonal and Communication skills, Professional Knowledge and Practice, Work Organisation and Management and Ethics and Equal Opportunities. A questionnaire for senior managers within the EPS has recently been developed.

There are many benefits of the 360-degree approach; it is a way of receiving feedback directly from the individuals who observe the behaviours being rated, rather than by a line manager who may have little knowledge of an individual's day-to-day performance. This is particularly true of personnel within the EPS, whose work is more generally observed by school staff than by EP colleagues. The 360 approach offers multiple perspectives on an individual, reducing biases in traditional appraisal approaches which can be subject to personality clashes or even corporate biases. 360 is relatively easy to administer and provides opportunities for confidential responses imparted directly onto the computer system which is likely to mean that responses are more objective. The results can provide a useful structure in which discussions relating to performance management might occur and it is reported that participants feel that it fosters a participative culture within the appraisal process (London and Beatty, 1993).

London and Beatty (op. cit.) also describe how 360-degree feedback can be a useful method of encouraging focused changes in individual performance, but state that in many 360 reviews, feedback is sought from colleagues and managers, but the views of the customer are ignored. It might be stated that in industry, the role of the customer is clearer than in the Public sector, for example within the educational psychology service, 'customer' could describe a number of client groups, including children/young people, parents, school staff, governors and other agencies. In order to gain a true

picture of customer perceptions, the viewpoints from members of all these groups should be gained.

### Weaknesses of the 360-Degree feedback approach

Although 360 can be viewed as a useful mechanism for feedback on an individual, there are also many issues that should be taken into account if it is to be used within an organisation. It can be argued that the feedback given by respondents to the 360-degree approach is rather subjective. Within the LEA, the individuals providing the feedback were chosen by the individual who was being rated and therefore it is likely that 'rated' individuals would choose respondents who would provide more positive feedback about their skills over colleagues who might provide challenging feedback.

Although the 360 degree questionnaire is reasonably comprehensive in terms of the number of questions and areas covered on an individual, it does not provide the opportunity for more qualitative comments and therefore does not provide a rich picture of the individual's strengths and weaknesses. It does not therefore give credit for specific achievements that relate specifically to the person being rated, for example acknowledgement for an exceptional piece of work or extraordinary achievement. 360 degree feedback is therefore of the 'one size fits all' model of feedback.

Due to the fact that 360 degree feedback is an individual assessment tool, it can be difficult to identify trends across teams in order for managers to be able to identify corporate training needs. It has been suggested that because there is an inherent expectation that 360 degree feedback will provide a plan that will lead to changes in practice and behaviours, tensions can be created amongst staff (London and Beatty 1993), however this same argument could be applied to Performance Management and the setting of outcome-based targets within Appraisals, such as those used within the County Council in which I am employed.

The feedback provided by the 360-degree approach achieves a balance between areas to 'celebrate' and areas to 'fix', although it is easy to distort this information. Managers seeking competency issues for an employee could distort the information in order to suggest that the 'fix' areas were areas of incompetence, rather than areas for development. Individuals who are not feeling at ease with their performance might be inclined to focus on the negative aspects of the feedback, whilst individuals who are very confident might focus more on the areas to celebrate. This clearly would not be helpful to either party. Atwater and Yammarino (1992) suggest that individuals who provide self-ratings that are in agreement with those of others are more likely to use that information to change their behaviours. It should be stated at this point that the difficulty with all feedback is that it is only as effective as the individual who receives it and their willingness to act upon it.

360-degree feedback is not designed to be a before-and-after measure of feedback. The cohort of individuals completing the responses may therefore be different over time and within the LEA, there is no specific intervention plan that relates to the 360-degree process, following up on the areas to celebrate or 'fix'. A specific action plan resulting from 360 both in terms of individual goals and organisational actions would appear to be key to the whole process and therefore ways of incorporating this into the existing mechanisms of professional feedback should be developed.

360 degree is an assessment tool of the individual and yet much of and EPs work relates to how effectively individuals operate within a team setting, either through working with EP colleagues, groups of teachers or school staff or in multi-agency work. 360 considers psychologists to be a collection of individuals rather than operating as a whole and therefore it is suggested that for Educational Psychology Services who are using 360, additional measures to explore effectiveness in working as a team should also be sought. It should be remembered however that the experience of schools, parents and children/young people relate primarily to meetings with an individual psychologist and therefore this individualised feedback does provide a valuable function for the individual.

It could be argued that an EP who receives extremely positive feedback from schools and colleagues using the 360 approach is not necessarily

operating successfully as a 'critical friend' within the school context. Paradoxically, this type of feedback is not necessarily a positive reflection of an individual's professional skills and an overly favourable report from colleagues might suggest a more informal relationship than is useful in terms of providing objective feedback. Feedback requested about individual EPs could also be subject to bias if it is linked to other agendas, for example bias could result from a school who was dissatisfied with an EP who offers a consultative approach to schools compared to an individual who considers an individual assessment approach to working with schools, if this was preferred by the member of staff who completed the questionnaire. Another source of bias could be introduced for individuals providing feedback on an individual educational psychologist using 360 if the distinction between providing feedback on the individual became blurred with providing feedback in relation to the organisation. When considering an individual's profile over time using a 360-degree approach, it is not possible to state the degree to which changes in perceptions are due to changes in the individual as opposed to changes within the organisation.

There has been considerable evidence to indicate that when comparing individual's self-performance ratings with ratings of those same individuals by others, there is little agreement between the two (eg Furnham and Stringfield 1998; Atwater and Yammarino 1992). When considering other people's ratings of the same individual, there is more conformity between responses. There has been some evidence that there may be a cultural

bias affecting these results (Furnham and Stringfield op.cit.), however, this is not consistent. Atwater and Yammarino (1992) have suggested that self-ratings tend to be higher than peer ratings due to a 'leniency effect' although interestingly this has not been observed when educational psychologists within my service who have completed 360 responses. It could be argued that in a culture that celebrates success, such as in the USA, a different profile would be noted than in the UK, where individuals have a reputation for modesty in this area. Gender differences amongst individuals completing self-ratings may be present because male culture encourages self-promotion and competition more overtly than feminine culture. Conversely, women have to do more self-promotion to achieve equal status within the workplace and therefore they might be more inclined to display a leniency affect within their responses.

Atwater and Yammarino (1992) link accuracy in self-reporting closely with self-esteem and self-awareness, with a leniency bias conflictingly being related to both high and low self-esteem and a high self-awareness. Individuals who have a high self-esteem and high self-awareness are likely to feel positive about their skills and achievements and will report these factors accordingly. Individuals with a low self-esteem however may not wish to report their perceptions of skills and competencies which they hold in low regard both as an emotional self protection mechanism and in an attempt to conceal their professional vulnerabilities from work peers and

managers. Accuracy in self-reporting may also link closely to emotional intelligence, although this is an area that requires further consideration.

How has the Model of CPD changed within the County Council perspective and what is the impact of this upon Personnel?

The County Council within which I am employed is currently undergoing a period of modernisation in order to achieve the vision of becoming a top performing Council. As part of the modernisation, the Council has set out five values and eight organisational aims which its employees are encouraged to work towards within their own departments. In 2003 an 'Achieving Top Performance' award scheme was developed in which Council employees could be nominated by colleagues or clients in order to celebrate successes and good practice, under each of the eight organisational aims. Over 1100 individuals from within the Council received nominations for their work, which provided a forum by which individuals received positive feedback from their employers in relation to their performance, and this was well received both by Council staff and the local community.

As part of the modernisation process, the issue of CPD was considered by staff within the Human Resources Department, who developed a system of outcome-based targets that would be negotiated with employees during the appraisal cycle. The targets are taken from an educational perspective and

adhere to the 'SMART' (Specific, measurable, achievable, realist and time-measured) format used in Education. The County Council have adapted this framework slightly by reframing the targets as 'SMARTS' which have the additional word 'Stretching' added to the previous five. The Council currently recommends that in addition to a formal annual appraisal, employees should have the benefit of an optional 3-month and 6-month follow up review. Within the EPS, a two-meeting approach has been adopted, with an appraisal in the summer term, followed by a 6-month review in February. An individual's line manager, who is also the supervisor of the person being appraised, conducts the meeting. Neither of these two processes are linked to the 360-degree feedback process, although it is anticipated that it could provide part of the rich picture in relation to an individual's performance as part of the review meetings. Within the county, targets set during appraisals are closely linked to service plans as a means of achieving organisational aims alongside the individual training needs of its members.

Hewton (1988) considers how the appraisal process can create feelings of suspicion within a workforce and therefore suggests that training should be available for both appraisers and appraisees. A training model for this process is offered which includes guidelines as to who should complete appraisals, how often they should occur and the preparation that should take place for them. Hewton (op cit) is prescriptive in his approach and there is little flexibility within the system that is proposed. It could therefore

be argued that this approach offers little in terms of gaining a rich picture of an appraisee's skills and training needs and that this model also adheres to the 'one size fits all' model of CPD.

Research suggests that reflection plays an important part in the CPD process although this is one area that is often ignored (Schon 1991). Schon suggests that research into work motivation indicates that workers want more than high productivity figures to achieve job satisfaction and that successful organisations are those who identify that a worker is an individual who has interests and development needs in addition to their corporate role. This viewpoint is supported by Gregory (2000) who considers the role of emotion in professional development opportunities, particularly in relation to the role played by intuition in making corporate decisions. This perspective also relates to psychological theory in relation to understanding of tacit knowledge and implicit learning (Polanyi 1967).

**What is the British Psychological Society's perspective on CPD?**

The British Psychological Society (BPS) describes CPD as benefiting the individual psychologist, their employer or business and the Society itself. CPD is encouraged within the BPS Code of Conduct and draft guidelines for CPD are published on the BPS website. The rationale behind this view relates to both ethical and professional competence issues. Within a climate where public-sector workers are increasingly operating within a free market context and are made more accountable for their professional roles and

efficacy, CPD mechanisms are viewed as a tool for providing evidence of an individual's skills and competencies.

This however appears to be rather a limited, outcome-based approach and one that was criticised in recent literature (Raven 2003). Raven argues that it is paradoxical for psychologists to use a deficit model in considering professional development, as this is not supported by EPs' knowledge and practice of psychological theory. The BPS support their framework for CPD in terms of describing how psychologists work in an increasingly litigious society in which individuals have to prove their competencies. In 2000, it was agreed by BPS members that CPD should be made compulsory and as a result of this, it is planned that individuals holding practicing certificates will need to submit an annual CPD summary to the Society. The society suggest that individual EPs should undertake 40 hours of CPD activities per annum, although the guidelines do not quantify whether this figure would be pro rata for part time staff and how this system would be regulated. There is also little information as to what constitutes CPD, for example it would be harder for them to prove that an individual had spent an afternoon in a research-based activity on the Internet, rather than attending a course at a training institution. The Guidelines suggest that EPs should employ a mentoring system, although there are obvious implications for this within the resources of the LEA, and these resources will be particularly stretched when the three-year training for EPs commences.

The concerns expressed about the content of the BPS draft guidelines do not negate the necessity for documentation to describe the expectations for the continuing professional development of EPs. In understanding factors that are important to adult learning however, it could be suggested that the guidelines be amended to embrace a more interactionist approach.

What ways forward can be suggested in terms of the development of CPD for EPs?

As a result of reviewing the literature and in particular in considering the strengths and weakness of the 360-degree feedback approach, it appears that CPD should be considered an interactive process that considers knowledge and skills, but also emotional competencies. In today's increasingly litigious society there is a move towards having to prove professional capabilities and therefore it is likely that there will always be a place for individual assessment tools such as 360-degree feedback. It is important that these tools are placed in context however and that the interpretation of the results should be considered alongside more traditional forums, such as the appraisal meeting in which a richer picture of the individual's strengths and weaknesses that are not bound by a specified format or agenda can be explored and discussed within a safe environment.

There is a clear need for educational knowledge to be underpinned by a theories that are challenged and reviewed, although there is evidence to suggest that teachers do not tend to make use of this body of information (Webster and Beveridge, 1997). Educational psychologists are placed in a unique position to support such work in terms of planning, conducting and reporting upon research and in disseminating this information to colleagues in schools. One of the constraints that has been identified by EPs in conducting research however is the need for EPs to receive appropriate training in research methodology and analysis (Webster and Beveridge, op cit). Opportunities for learning from experienced colleagues are not always available, although this aspect of CPD is also essential to support individual's reflections in relation to their personal skills and competencies (Mellor 1998). It is therefore suggested that collaborative working and shadowing should be adopted as part of the CPD process within psychology services both to allow colleagues to share skills and knowledge and for managers to gain a picture of training needs within the team.

## **Integration of Research and Practice**

The necessity for educational psychologists to have access to high quality CPD experiences has been identified within the literature and has been made compulsory for members of the British Psychological Society. The significance of CPD for EPs is derived not only from the need to be aware of the ethical and professional issues that are central to the work of an EP, but also in order to respond to the rapid pace of change both within education and educational psychology.

Self-reflection has been identified as an important aspect of the process of CPD and 360-degree feedback is a tool that can help to structure the process of this reflection. It is however, subject to a number of limitations that have been described within this assignment. One aspect of 360 that receives little attention within the literature is how it feels to receive this type of feedback and how positive a process 360 is perceived to be by those undertaking the process. Feedback elicited by 360 in relation to my own skills and competencies is therefore described hereafter and my reflections are included in relation to how it feels to participate in the process. This should therefore be viewed as one individual's journey through 360 rather than a representative view, either of my EP Service or of EPs more generally.

### **Results of the 360 degree feedback questionnaires**

I have completed the 360 'experience' on two occasions, in 2000 and 2003. In 2000, the feedback was derived from both EP colleagues and from teachers from the schools to whom I was known as the link EP. In 2003 the feedback came from EPs and school staff from a different group of schools, who also knew me as their link EP. On both occasions the questionnaires were sent to eight colleagues, four teachers and four EPs. In 2000, seven colleagues completed responses whereas in 2003, only five responses were received. In comparing the information from the two profiles, it is important to revisit the fact that this tool is not designed as a pre and post measure assessment, rather a profile of current performance from a range of personnel.

When considering the raw scores and means from the two profiles (see Appendix One), it is interesting to note that every item on the 'Performance' part of the questionnaires from colleagues are higher than the self rating of my performance, in each of the four areas. This was also the case in 2003, although the gap has narrowed in terms of the personal views of my performance compared to those of my colleagues. In one area, 'Professional Knowledge and Practice', this has been because I have rated my own performance as being higher in 2003 than in 2000, but in other areas, colleagues have provided me with lower ratings. This is in conflict with literature on the subject of self-rating and peer-ratings, which tends to

describe a leniency effect that inflates individual scores (Atwater and Yammarino 1992). In order to explore this further, I have considered each area in turn.

#### *Interpersonal and communication skills*

The importance of this area was agreed over time both in terms of self-ratings and those of colleagues. Colleagues felt that this, out of all of the four areas of EP practice, was the most important overall and this was consistent amongst the different individuals who completed the questionnaires on each occasion. The 360 approach had therefore successfully identified an aspect of the EP role that was important to EPs, their colleagues and staff in schools. From a personal perspective, this area is extremely important to my work as I perceive effective relationships to be at the heart of the work of the EP, an area which is successfully fostered through appropriate interpersonal and communication skills.

In 2000, my EP and teaching colleagues ratings of me in this area achieved an overall mean score of 5.7 that relates to ratings of 'Very Well/Exceptionally well'. In 2003, this mean had settled to a mean of 5, relating to 'Very Well'. In reflecting upon my performance, my initial response to this discrepancy in scores was disappointment, as there appeared to be a reduction in how well I was performing in this area. This feeling of discomfort was then replaced by a series of questions relating to which items had influenced the mean scores and to what extent. The

process of working through these questions produced some tantalising information in relation to my performance and more questions than answers were elicited.

When examining the distribution of the scores, it was difficult to identify how the trend has been generated; this is because the statistical analysis focuses upon not only the score that has been provided by the individual who is completing the questionnaire, but also the importance rating that they have given to the item. What was clear was that throughout the four areas, one response was consistently lower than the others. It is not possible to say whether this was one individual who was inclined to give lower ratings than the other respondents, or whether each of the respondents gave a significantly lower rating than the others on some of the items. Receiving this feedback therefore felt quite frustrating, as it was not possible to hypothesise why this type of feedback was given and there was no evidence base to substantiate the views of the respondents. 360 does not therefore answer the question of what aspects of my work colleagues within the EPS and schools find valuable and what information these judgements are based upon. This therefore makes it difficult to plan professional development as a result of the 360 process and also seems to be in conflict with psychological knowledge of the importance of evidence based practice.

***a) Professional knowledge and practice***

As in the 'Interpersonal and communication skills' section, this area was agreed over time in terms of the level of importance that was assigned to the items by myself and my colleagues. Some surprising responses were also recorded however, which raised questions in relation to the aspects of the EP role that schools value the most. Out of the five respondents in 2003, two individuals recorded that it is 'quite important' for EPs to be up to date on current theory and research, rather than 'very important' or 'extremely important', and one person felt that it is only 'quite important' for EPs to identify possible solutions to concerns. This was an unexpected response, as I had previously believed that colleagues within the EPS and schools recognise and value the unique psychological perspective offered by EPs to educational concerns within schools. This response also raised questions as to whether the colleagues who provided these responses were from the EPS or schools and how this could be considered further when the responses were confidential.

In terms of my own professional knowledge and practice, this is an area in which I recorded that had made some improvements and I felt that my knowledge of psychological theory and research had improved directly as a result of my work on the DEdPsy Course. More specifically, I believe that I have become more analytical in the way that I approach problem solving in schools through my increased knowledge and confidence and in using a range of research designs and evaluating what has worked in practice. It

could be hypothesised that not all school staff welcome this approach to problem solving and would prefer an 'expert model' in which responsibility for the problem is deferred away from the school. This could be one reason why the 'performance' ratings were lower in 2003 because some staff felt challenged by this change in my practice. This begs the question as to what are the services that we as an EPS should be offering to schools, a question that may be definitively answered if budgetary responsibility for the EPS is delegated to schools and school staff control the nature of services that they wish to purchase.

*b) Work organisation and management*

This area had not altered in terms of importance for myself or my colleagues. My own perception was that this had not changed in terms of my performance between 2000 and 2003; however as for other areas within the 2003 responses, one was consistently lower than the others, reducing the overall mean score achieved. One example of the inconsistencies within the responses was on the item that states; "Gives sufficient notice of changes in time", where 1 respondent had recorded 'exceptionally well', 3 recorded 'very well' and 1 recorded 'not very well'. This lack of consensus was part of a pattern observed within the 2003 responses that was not seen previously. This pattern is atypical of processes in which individuals are required to rate another person's performance as generally, high levels of agreement are recorded (Atwater and Yammarino 1992). Reasons for low inter-rater reliability by one person might relate to the perceptions of that

individual about the service that they have received, but may also be concerned with personality differences or anxieties that relate to the organisation rather than to the individual EP. Once again, this information is both tantalising and frustrating as there are no methods by which these hypotheses can be explored or tested further.

*c) Ethics and equal opportunities*

A similar profile was seen to the 'work organisation and management' section and again some surprising responses were identified. One respondent recorded that it is 'quite important' for EPs to gain parental permission prior to their involvement with a child as opposed to being 'very important' or 'extremely important'. This was a professional revelation, as I believed that all schools were aware of the professional code of conduct under which EPs are bound. My response to this information has been to consider the other assumptions that need to be challenged and clarified during my work in schools as well as a necessity for defining my role and involvement more carefully. It should be acknowledged however that such a small in such a small sample of responses (5 people), the data is easily distorted and that this should be accounted for in considering the results of any 360 profile.

**Reflection in relation to the responses**

It was interesting to note that within the questionnaire responses, I appear to describe myself as a 'reasonable all-rounder', with no specific strengths

and weakness in terms of my performance. Colleagues however rate my areas of strength as being in my interpersonal and communication skills and in my commitment to ethics and equal opportunities, which interestingly are also the areas that colleagues rate as being of the highest importance. According to my colleagues, the biggest dip in my performance over time appears to relate to my organisational and management skills. Upon reflection, and considered from an external locus of control viewpoint, this could well be related to the additional demands that have been placed upon me within the past four years on an organisational, personal, health and emotional level. If I was to consider internal factors to explain this difference, personality factors may have contributed to any perceived change, in particular because I enjoy taking on multiple demands as a source of motivation. The downside of this however is that it is not always possible to meet multiple demands to the high expectations that might otherwise be achieved.

I would also suggest that the organisation of EP work is greatly facilitated by the organisation of the school, for example where IEPs and paperwork are sent in advance to the EP it is easier to be more efficient with time. I feel that over time, my relationship with some schools has become closer, the benefit of this being that it is possible to gain a real insight into the systems that are in place and that as an EP it is easier to facilitate change if one is liked and trusted by the staff. The disadvantage of building a particularly close relationship with a school however is that sometimes individuals lower

their expectations of what should be done prior to an EPs visit and a less efficient use of EP time is made.

I have found it fascinating to see that two of the areas that colleagues helped me to celebrate in 2000 are now on my 'fix' list in 2003 –see appendix 2- ('Follows through on commitments' and 'Keeps people informed'). From this profile, I feel that there are issues relating to the amount of my time that people perceive that they have access to at the current time, as opposed to the time available in 2000. I can hypothesise that there may be some causal links between the personal stresses upon me, such as having a young son, which allows less flexibility in terms of staying later at work to complete pieces of casework and in following through on commitments to the same degree that I might have done prior to having my son. I could also suggest however that this could be related to the different cohorts of colleagues who completed the questionnaires on both occasions. In 2000, I was working in a modest, but challenging patch of 14 schools in a large town. These schools were allowed a higher number of EP visits per year from within the service due to their level of perceived need within the Authority. This allowed the opportunity to work in an in-depth way and the luxury of providing the schools with a significant amount of EP time. Within the current time however, I have a patch of 22 schools with are have a wide geographical spread across several small towns and villages. This naturally leads to spending more time in travelling between schools and in developing less in depth relationships with the school staff

with whom I work. It should also be stated that at the time when my colleagues completed their 360 responses in 2003, I was busy in the data collection phase of my DEdPsy research, which also meant that I had less time and consequently less flexibility to offer to schools.

### Reflection in relation to the process

The 360 process is a skills-based model of reflection against specific criteria, and not an assessment tool that aims to consider potential and therefore the feedback that is offered by 360 must be placed firmly within this context. The process is useful as an assessment tool if it is combined with additional methods of feedback that are able to consider an individual's emotional competencies in order to support the individual through the development process. Within my experiences of 360 there have been no opportunities to discuss the feedback given to me, although this has been identified as a weakness within the EPS and time for this activity is now being built in to supervision sessions. 360 does not offer the chance to develop a rich picture of an individual's achievements which, in my own case included a promotion within the service and being awarded one of the Council's Achieving Top Performance awards for focusing on customer need. The 360 model therefore contributes to the deficit model of understanding individuals, that 'one size fits all' and that people within a workforce should all be measured against the same criteria.

When completing the 360 process, it is important that some training should be given on how to interpret the results which can appear to be confusing. This confusion may also create feelings of anxiety for those individuals receiving feedback, which is likely to lower professional self-esteem. Within the process there needs to be opportunities to develop a plan of action as a result of the feedback in order to challenge and motivate the individual, an expectation that is not present at the current time. Methods should also be sought to identify corporate training needs across the team by identifying trends and common themes.

## **Conclusions**

Within recent years there have been considerable changes within education and educational psychology that have been observed at both a national and local level. Images of the market place have been applied to schools and this has in turn affected support services who have adapted to meet the new challenges presented to them.

Within this changing environment, the need for high quality CPD experiences and opportunities for self-reflection are essential, although views differ in relation to how this process is best achieved. One mechanism that encourages self-reflection is the 360-degree feedback model, which provides a structure by which skills and competencies can be measured against a series of criteria. From completing this process on two occasions during the course of my Doctorate in Educational Psychology programme a number of issues were raised, in particular that the process needs to be carefully planned and managed to reduce anxiety for the individual who is receiving the feedback. The process is not a 'stand alone' method of gaining feedback as it does not provide a qualitative picture of the individual's strengths and weaknesses and it can raise more questions than it answers in relation to the individual's performance.

In 2000, the DFEE clearly stated that training and development was crucial to the future role of educational psychologists (DFEE 2000). Developing,

testing and reviewing methods to understand the training needs of individuals and of services will therefore continue to remain central to identifying the potential of educational psychologists working within the LEA and it is argued that this will benefit both EPs in terms of job satisfaction and services in terms of the retention of high quality staff. It should be acknowledged however that the application of psychological knowledge needs to be applied to this process to celebrate the individual differences within teams and individuals, rather than apply a 'one size fits all' deficit model to understanding professional development.

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## **APPENDIX ONE**

### **360 degree raw data from questionnaires**

**Table One: Interpersonal and Communication skills**

	<b>IMPORTANCE</b>			
	<b>Self Ratings</b>		<b>Colleagues Ratings</b>	
<b><u>Item</u></b>	<b>2000</b>	<b>2003</b>	<b>2000</b>	<b>2003</b>
<b>1</b>	<b>3.0</b>	<b>3.0</b>	<b>3.0</b>	<b>3.8</b>
<b>2</b>	<b>3.0</b>	<b>3.0</b>	<b>3.7</b>	<b>3.6</b>
<b>3</b>	<b>3.0</b>	<b>4.0</b>	<b>3.7</b>	<b>4.0</b>
<b>4</b>	<b>4.0</b>	<b>4.0</b>	<b>3.9</b>	<b>3.8</b>
<b>5</b>	<b>4.0</b>	<b>4.0</b>	<b>4.0</b>	<b>3.8</b>
<b>6</b>	<b>4.0</b>	<b>4.0</b>	<b>3.7</b>	<b>4.0</b>
<b>7</b>	<b>4.0</b>	<b>4.0</b>	<b>3.9</b>	<b>4.0</b>
<b>8</b>	<b>3.0</b>	<b>4.0</b>	<b>3.7</b>	<b>4.0</b>
<b>9</b>	<b>4.0</b>	<b>4.0</b>	<b>3.6</b>	<b>3.8</b>
<b>10</b>	<b>4.0</b>	<b>4.0</b>	<b>3.6</b>	<b>4.0</b>
<b>11</b>	<b>4.0</b>	<b>4.0</b>	<b>4.0</b>	<b>4.0</b>
<b>12</b>	<b>4.0</b>	<b>4.0</b>	<b>4.0</b>	<b>4.0</b>
<b>13</b>	<b>4.0</b>	<b>4.0</b>	<b>3.9</b>	<b>4.0</b>
<b>14</b>	<b>3.0</b>	<b>3.0</b>	<b>3.6</b>	<b>3.8</b>
<b>Section</b>	<b>4.0</b>	<b>3.9</b>	<b>3.8</b>	<b>3.9</b>
<b>Mean</b>				

	<b>PERFORMANCE</b>			
	<b>Self Ratings</b>		<b>Colleagues Ratings</b>	
<u>Item</u>	<b>2000</b>	<b>2003</b>	<b>2000</b>	<b>2003</b>
<b>1</b>	<b>4.0</b>	<b>4.0</b>	<b>5.6</b>	<b>5.0</b>
<b>2</b>	<b>4.0</b>	<b>4.0</b>	<b>5.4</b>	<b>5.0</b>
<b>3</b>	<b>4.0</b>	<b>3.0</b>	<b>5.7</b>	<b>5.2</b>
<b>4</b>	<b>4.0</b>	<b>4.0</b>	<b>5.9</b>	<b>4.8</b>
<b>5</b>	<b>5.0</b>	<b>5.0</b>	<b>6.0</b>	<b>5.0</b>
<b>6</b>	<b>5.0</b>	<b>5.0</b>	<b>5.7</b>	<b>5.0</b>
<b>7</b>	<b>4.0</b>	<b>4.0</b>	<b>5.1</b>	<b>4.8</b>
<b>8</b>	<b>3.0</b>	<b>4.0</b>	<b>5.6</b>	<b>4.6</b>
<b>9</b>	<b>4.0</b>	<b>3.0</b>	<b>5.4</b>	<b>5.4</b>
<b>10</b>	<b>4.0</b>	<b>4.0</b>	<b>5.9</b>	<b>5.4</b>
<b>11</b>	<b>4.0</b>	<b>3.0</b>	<b>6.0</b>	<b>5.2</b>
<b>12</b>	<b>3.0</b>	<b>4.0</b>	<b>6.0</b>	<b>5.0</b>
<b>13</b>	<b>3.0</b>	<b>4.0</b>	<b>5.6</b>	<b>5.2</b>
<b>14</b>	<b>3.0</b>	<b>3.0</b>	<b>5.4</b>	<b>5.0</b>
<b><u>Section</u></b>	<b>4.0</b>	<b>4.0</b>	<b>5.7</b>	<b>5.0</b>
<b><u>Mean</u></b>				

**Table 2: Professional Knowledge and Practice**

	<b>IMPORTANCE</b>			
	<b>Self Ratings</b>		<b>Colleagues Ratings</b>	
<u>Item</u>	<b>2000</b>	<b>2003</b>	<b>2000</b>	<b>2003</b>
<b>15</b>	4.0	4.0	3.3	3.4
<b>16</b>	4.0	4.0	3.3	3.5
<b>17</b>	4.0	4.0	3.6	3.4
<b>18</b>	4.0	4.0	3.0	3.0
<b>19</b>	3.0	4.0	3.6	3.2
<b>20</b>	3.0	4.0	3.1	3.2
<b>21*</b>	4.0	N/A	3.6	N/A
<b>22 (21)</b>	3.0	4.0	3.7	3.6
<b>23 (22)</b>	3.0	3.0	3.6	3.6
<b>24 (23)</b>	3.0	4.0	3.7	3.8
<b>25(24)</b>	3.0	4.0	2.7	3.4
<b>26(25)</b>	4.0	4.0	3.3	3.8
<b>27(26)</b>	3.0	4.0	3.5	3.6
<b>28(27)</b>	3.0	4.0	3.3	3.8
<b>29(28)</b>	3.0	3.0	3.3	3.3
<b>Section</b>	<b>3.4</b>	<b>3.9</b>	<b>3.3</b>	<b>3.5</b>
<b>Mean</b>				

	<b>PERFORMANCE</b>			
	<b>Self Ratings</b>		<b>Colleagues Ratings</b>	
<u>Item</u>	<b>2000</b>	<b>2003</b>	<b>2000</b>	<b>2003</b>
<b>15</b>	3.0	4.0	4.9	4.6
<b>16</b>	3.0	4.0	5.3	4.5
<b>17</b>	3.0	4.0	5.3	4.8
<b>18</b>	3.0	3.0	5.0	4.7
<b>19</b>	3.0	4.0	5.4	4.8
<b>20</b>	3.0	5.0	5.0	4.8
<b>21*</b>	3.0	N/A	5.3	N/A
<b>22(21)</b>	3.0	5.0	5.4	5.0
<b>23(22)</b>	4.0	4.0	5.6	4.8
<b>24(23)</b>	4.0	4.0	5.7	5.0
<b>25(24)</b>	3.0	3.0	5.1	4.6
<b>26(25)</b>	4.0	4.0	6.0	5.0
<b>27(26)</b>	4.0	4.0	5.5	5.0
<b>28(27)</b>	3.0	4.0	5.5	4.5
<b>29(28)</b>	3.0	4.0	5.3	4.7
<b>Section</b>	<b>3.0</b>	<b>4.0</b>	<b>5.4</b>	<b>4.8</b>
<b>Mean</b>				

\* Item 21 was not included in the second questionnaire. The numbers in brackets therefore describe the number given to each item in the second questionnaire.

**Table 3: Work Organisation and Management**

	<b>IMPORTANCE</b>			
	<b>Self Ratings</b>		<b>Colleagues Ratings</b>	
<u>Item</u>	<b>2000</b>	<b>2003</b>	<b>2000</b>	<b>2003</b>
<b>30 (29)</b>	3.0	4.0	3.6	3.8
<b>31(30)</b>	3.0	4.0	3.4	3.4
<b>32(31)</b>	4.0	4.0	3.6	3.2
<b>33(32)</b>	4.0	4.0	3.9	3.4
<b>34(33)</b>	4.0	4.0	3.6	3.4
<b>35(34)</b>	4.0	4.0	3.4	3.8
<b>36(35)</b>	4.0	4.0	3.4	3.4
<b>37(36)</b>	4.0	4.0	3.7	3.8
<b>38(37)</b>	4.0	4.0	3.7	3.6
<b>39(38)</b>	4.0	4.0	4.0	4.0
<b>40(39)</b>	4.0	4.0	4.0	4.0
<b>Section</b>	<b>3.8</b>	<b>4.0</b>	<b>3.7</b>	<b>3.6</b>
<b>Mean</b>				

	<b>PERFORMANCE</b>			
	<b>Self Ratings</b>		<b>Colleagues Ratings</b>	
<u>Item</u>	<b>2000</b>	<b>2003</b>	<b>2000</b>	<b>2003</b>
<b>30 (29)</b>	4.0	3.0	5.7	4.8
<b>31(30)</b>	4.0	4.0	5.7	5.0
<b>32(31)</b>	3.0	5.0	5.7	4.2
<b>33(32)</b>	4.0	4.0	5.7	4.6
<b>34(33)</b>	4.0	4.0	5.5	4.8
<b>35(34)</b>	4.0	4.0	5.4	5.2
<b>36(35)</b>	3.0	4.0	5.3	4.6
<b>37(36)</b>	4.0	4.0	5.6	4.8
<b>38(37)</b>	4.0	4.0	5.6	4.8
<b>39(38)</b>	4.0	4.0	5.8	4.6
<b>40(39)</b>	4.0	4.0	5.9	4.6
<b>Section</b>	<b>4.0</b>	<b>4.0</b>	<b>5.6</b>	<b>4.7</b>
<b>Mean</b>				

**Table 4: Ethics and Equal Opportunities**

	<b>IMPORTANCE</b>			
	<b>Self Ratings</b>		<b>Colleagues Ratings</b>	
<u>Item</u>	<b>2000</b>	<b>2003</b>	<b>2000</b>	<b>2003</b>
<b>41(40)</b>	3.0	4.0	3.7	3.6
<b>42(41)</b>	4.0	4.0	3.9	3.8
<b>43(42)</b>	4.0	4.0	3.7	3.4
<b>44(43)</b>	4.0	4.0	3.9	3.8
<b>45(44)</b>	4.0	4.0	3.9	3.4
<b>Section</b>	<b>3.8</b>	<b>4.0</b>	<b>3.8</b>	<b>3.6</b>
<b>Mean</b>				

	<b>PERFORMANCE</b>			
	<b>Self Ratings</b>		<b>Colleagues Ratings</b>	
<u>Item</u>	<b>2000</b>	<b>2003</b>	<b>2000</b>	<b>2003</b>
<b>41(40)</b>	4.0	4.0	5.1	5.0
<b>42(41)</b>	4.0	4.0	6.0	5.6
<b>43(42)</b>	5.0	4.0	5.3	5.0
<b>44(43)</b>	4.0	5.0	5.9	5.0
<b>45(44)</b>	5.0	5.0	6.0	5.0
<b>Section</b>	<b>4.0</b>	<b>4.0</b>	<b>5.7</b>	<b>5.1</b>
<b>Mean</b>				

## **APPENDIX TWO: Priority Areas to celebrate and fix, 2000/2003**

### **Overall areas to celebrate using feedback from colleagues**

#### **i. 2000**

- Develops effective working relationships
- Listens well and responds appropriately
- Is honest and open in her communication
- Keeps people informed
- Follows through on commitments

#### **ii. 2003**

- Takes others' concerns seriously
- Treats people with respect
- Makes sure she understands the context within with others work
- Listens well and responds appropriately
- Is easy to understand

## **Priority areas to fix using feedback from colleagues**

### **i. 2000**

- Practice is based upon appropriate knowledge of theory and research
- Checks that they have understood accurately what has been said
- Takes others' views into account before acting
- Has good knowledge of the range and organisation of special educational support and provision for children locally
- Is up to date with current psychological research

### **ii. 2003**

- Arrives on time
- Takes time to discuss how any solution will work within a particular context
- Explains how she will address the needs identified
- Follows through on commitments
- Keeps people informed