Early Support
Helping every child succeed

Working in Partnership through Early Support: distance learning text

Knowing yourself and the family

by
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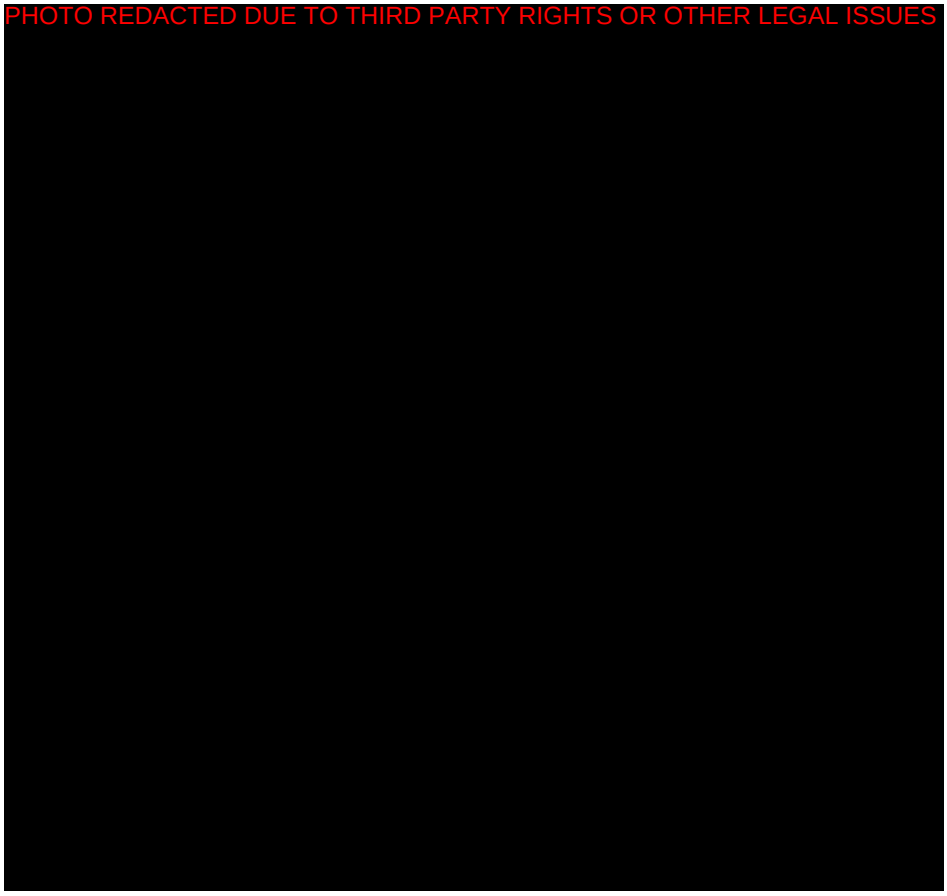

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Introduction

This chapter focuses upon the ways in which you develop knowledge about yourself and the families with whom you work or live. It encourages you to think about the sorts of knowledge that professionals and families have. It encourages you to think about how you use that knowledge. At the centre of this chapter is the idea of reflexivity. It is a critical look at the ways in which we think and work and the impact that this has upon the early intervention participants. As you read this chapter you need to be reflective. Think about all that it discusses in the context of your own work, personal actions and development.

At the end of this chapter you will have examined:

- Different forms of knowledge
- The notion of knowledge as power
- The impact of early intervention on the family
- The need to consider the views and values of all the family
- Different forms of assessment
- Methods of capturing observations
- How to ask questions of yourself
- Your views on your relationships with children, families and other professionals
- The notion of effectiveness.

Thinking about knowledge

Professional knowledge

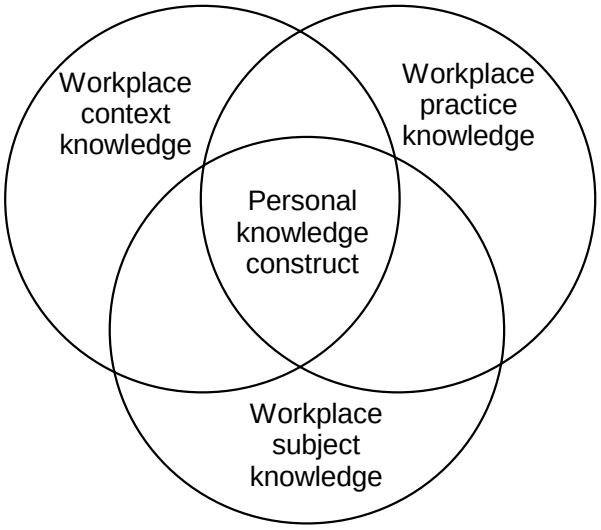
Once people have a shared understanding of some aspect of life they become part of a specific social group…a group who have that shared understanding. Such shared understandings define our membership of groups and cultures in many different settings within our society and across societies. Professionals working with young children are members of a number of such groups, and so are the parents of these children. The knowledge you use at a given time varies depending on the grouping you represent, its functions, and working practices, as well as your personal perspectives of that knowledge and your role.

Professional knowledge that is drawn upon in supporting families can be represented in this way (though all of these forms of knowledge overlap and interconnect):

1. **Workplace subject knowledge** – relates to the academic, theoretical and experiential knowledge that is considered key to that professional's tasks (eg: models of language development for a speech and language therapist).
2. **Workplace practice knowledge** – relates to understanding of how best to work in the setting, and how to work with others (eg: for a teacher – pedagogy, how to make information accessible and to encourage its learning).
3. **Workplace context knowledge** – relates to understanding the role of subject and practice knowledge and their constant transformation for the workplace; and the historical and ideological construction of this knowledge and of the workplace (eg: understanding why early

intervention recording materials were created and their impact on professionals and parents).

4. **Personal knowledge construct** – relates to a practitioner's own interpretations of knowledge in relation to their own social and cultural contexts (ie: your expertise is founded on your personal construction of all the knowledge types you need for your role).



(Based on Banks, Leach and Moon, 1998)[1]

Knowledge and power

It is commonplace to describe members of professional groupings as experts within their field, because of the knowledge that membership implies. It is easy to see the hard-won workplace subject knowledge as superior to the practice and context knowledge gathered through day-to-day experience. Our membership of such groups encourages this thinking too. Expertise is a social construct however, just as the knowledge is. It requires people to acknowledge it before it becomes meaningful.

The emphasis placed on workplace training (such as this course) is an example of the meaning attached to this expert knowledge. By demonstrating learning and the acquired expert knowledge, the professionals amongst you are allowed to take on additional responsibilities and make a wider range of decisions. You gain power through your knowledge – this is socially constructed power. The fact that this course is also available to parents demonstrates the importance now placed on empowering parents to play a meaningful role in decision making. Parental access to professional knowledge fundamentally changes the way in which they can be approached by practitioners.

The power you have through your professional knowledge in many ways constitutes who you are, but at the same time you are the vehicle of that power (Foucault, 1978, 1980). Therefore, professional power potentially creates a gap between parents and professionals. Parents often know less about systems and theories than the people who are supporting them. They rely upon the professional's knowledge to gain access to the early years systems and ways of thinking. Practitioners potentially have power over these people. Power though is not one-directional, neither is it a commodity. It is "neither given, nor exchanged, nor recovered, but rather exercised, and … only exists in action." (Foucault, 1980, p89). Power comes into existence

[1] You could try the first activity for this chapter at this point – it can be found at the end of the chapter.

when you interact in relationships; it is part of a net-like arrangement, so that all those involved in the relationship have a capacity to impact upon that power. For example, a parent can invalidate the practitioner's power by ignoring their advice.

In early years work it is particularly important practitioners acknowledge and support parental power. A central notion in early years work is that the parents are the primary experts on their children. All parents (including those not doing this course) have unique knowledge about their children. In addition, they are the people through whom negotiation of support services are conducted. They are the gatekeepers to the child. The early intervention professional and the family are both operating upon a power-knowledge axis and this has a key bearing upon the success of their relationship.

Developing parental involvement

Why focus on the family?

Human beings do things together. We are born with certain characteristics that encourage us to explore and develop in a recognisable way, but without the support of the people around us we gain very limited access to the human and physical world. The author once spent a few days on a working visit to an Albanian Orphanage. Here the children were only picked up at predetermined times, regardless of their personal needs, to be changed and fed. When I played with one eighteen month old child, it took him one and a half hours to respond to my presence. This child did not know that my presence had potential meaning for him. Without the supportive intervention of others he was unable to gain access to the world around him.

This realisation that knowledge is socially constructed by the form and quantity of interactions with others was one of the central insights offered by child psychologist, Lev Vygotsky. He identified the role of the wider social and cultural environment in learning, concluding that we cannot understand a child's development by studying the individual alone. Children can learn things about the world through physical exploration, as Jean Piaget recognised, but it is rare for them to be left entirely alone in any activity for long. At some point an adult or carer will intervene. The carer introduces new ideas, language and opportunities that stretch the child's learning as it develops. Vygotsky referred to this supportive learning as taking place within the Zone of Proximal Development (Vygotsky, 1986). This is not the same as simply saying we learn from people who are older and wiser. Knowledge cannot be passed from one brain to another, as a car can pass between owners. Ideas have to be interpreted.

As learners we have to construct anew any knowledge and skill which we experience. This is why we need to be involved in a shared, interactive process, to increase the possibility of coming to similar understanding as others exploring the issue or experience. This understanding of the learning process is at the heart of current early years practice. Young children (and everyone else) need to be supported in coming to understand the world around them and in developing the skills and abilities to prosper within it.

Understanding the family

It has been increasingly recognised that early intervention programmes need to be family-centred. (McBride and Peterson, 1997; Hanson and Carta, 1995; Wayman, Lynch and Hanson, 1990). They need to be built around the central, active role of parents and family in the care of their children (Baird and Peterson, 1997; Murphy, Lee, Turnbull and Turbiville, 1995; Pearl, 1993). Family-centred practice recognises the family as the experts on their children, and the ultimate decision makers about both child and family. Professionals have a temporary relationship with the child, whereas the family are a constant. Understanding the family, its priorities and choices is, therefore, essential both in relation to goals and services, as well as to the level and form of their participation. To be effective, professionals need to establish a trusting, collaborative relationship with the family, respecting the family's beliefs, values, cultural identity and ways of coping (Baird and Peterson, 1997; Dunst, Trivette and Deal, 1988; Murphy et al, 1995; Pearl, 1993).

Parents commonly report a sense of powerlessness during the initial diagnosis and decision making process about their child, as they go from professional to professional. On average they see ten different professionals and have more than 20 visits to professionals in a year (Sloper, 2004). One young mother of a child with autism described the intensity of the experience:

> "Between the ages of 20 months and 3 years and 9 months Colin was seen by dozens of health professionals, including several community medical officers, audiologists, ear, nose and throat (ENT) specialists, speech therapists, psychologists, paediatricians, and occupational therapist, a physiotherapist, and several health visitors." (Keenan, Kerr and Dillenberger, 2000, p64).

Parents need to have a sense of control over their family life and to recognise that effective intervention strategies result from their own actions, strengths and capabilities (Mahoney and Wheedon, 1997; Dunst et al, 1988). By directly involving parents in the development and implementation of programmes to support their child, parents feel more in control of the situation and the skills they require to carry out interventions. Parents are also more likely to feel that their relationship with professionals is improved (Dillenburger, Keenan, Gallagher and McElhinney, 2002). This sense of empowerment through the sharing of knowledge and involvement in decision making is a key part of the current early intervention strategy.[2]

The impact of professional ways of thinking

Much of the early intervention literature highlights the importance of self-directed learning. Buckley and Bird (1995), for example, in relation to children with Down syndrome, talk about 'setting up situations designed to enable the child to learn through play or exploration' (p2), so parents can assist their children to 'learn in a natural way' (p4). However, practitioners also require therapeutic activities to take place, 'designed to teach by practising small steps with the child, prompting and enabling them to see how to complete the task successfully' (pp2–3). The tension between these two foci is potentially problematic, because as Bridle and Mann (2000) point out, "play and therapy are not the same thing." (p13).

[2] You could try the second activity for this chapter at this point – it can be found at the end of the chapter.

Parents identify this difference between play and therapy. In many ways they expect to be involved in child-focused therapeutic activities (McWilliam, Tocci, and Harbin, 1995) and are satisfied to be so (McBride, Brotherson, Joanning, Whiddon and Demmitt, 1993). Such expectations may come from their expectations of the programme, their own priorities, and their lack of understanding of the importance of family. Equally possible is that this view reflects the professional's concerns with the in-child need (McBride and Peterson, 1997). As mentioned above, parents are often unequal partners when it comes to the professional understanding of development, as well as being uncertain about what it is they want for their child, particularly in the early years (Bridle and Mann, 2000). This makes them more likely to accept the views and recommendations of the professionals with whom they are working. Parents commonly come to view the effectiveness of their early intervention interactions with their child not according to how much the child enjoys themselves, but the degree to which they are learning in relation to targets. This means their focus shifts from appreciation of the present to what can be achieved in the future.

> "I always thought OK, the most important thing to do was stimulating him, ok, have him sitting up... instead of just bloody enjoying it." (Bridle & Mann, p13).

Many parents describe their commitment to professional checklists and goals, and identify achieving these goals as the most rewarding learning experiences with their child (Rix, Paige-Smith and Jones, 2005). This non-critical acceptance of the professional way of thinking echoes changes to the ways in which parents view their child. Many parents, for example, come to discuss characteristics of their child in terms of development, as opposed to personal interests and likes. One mother, for example, described her daughter's dislike of stereotypically male toys in the following way:

> "There are things like, if you're looking at toy things, with Chloe some of the stuff she just wasn't developmentally ready for. So we've had to put them to one side. Things like doing, building car tracks and getting cars to go around, doing that sort of imaginative play." (Rix et al, 2005, p11).

This professionalising of the parent carries some clear risks. Bridle and Mann (2000, p10) described how this felt to them:

> "While most people these days would not deny the 'humanity' of people with a disability, it still seems to be much easier to respond, with therapy, to identified problems and 'deficits' than to accept, encourage and support people to be who they are, disability included. We are still, through this system, separating children, and creating the 'special needs' family."

In much of the research cited above, most parents have high regard for some of the professionals with whom they have worked. They value their support and the contribution they make to their child's development. Parents want information about their child, too. They want to have much more information than most professionals expect, as was made clear in the parent consultations surrounding the early intervention support materials. Nonetheless, as a practitioner, how you talk about a child reflects how you think about a child, and this has a direct bearing on the views of the parent.[3]

[3] You could try the third activity for this chapter at this point – it can be found at the end of the chapter.

The impact of early intervention upon family life

Parents are keenly aware of their responsibilities as early interventionists. They often feel under great pressures to support their children in any way that they can (Paige-Smith and Rix, 2006). One father expressed his aspirations as a parent, and the pressures he felt himself to be under:

> "When you have a child with a special need, you see this is our first child, you feel helpless, you feel as though you want to do everything that you can possibly do…"

Some parents have the time and facilities to commit their lives to this early intervention. As one mother has explained in relation to her daughter:

> "She has had a lot of input at home, we simply don't waste an opportunity."

But other parents do not have the same scope for engagement. As a consequence, they will often feel guilty at their inability to carry out the activities being expected of them (Rix et al, 2005). One mother described her feelings:

> "I'll not do enough, and then I'll be feeling guilty because I'm not doing enough, and then will suddenly go through a phase of doing lots. So erratic."

Practitioners need to recognise that most parents see activities as essential for their child's development. They feel that through the activities they are directly responsible for the rate of progress that the child makes. As a consequence, many parents will feel that if they merely 'play' with their child and do not carry out the activities then they are in some way restricting their child's development (Bridle and Mann, 2000; Paige-Smith and Rix, 2006). Early intervention can easily become a cause of parental self-doubt and create an additional sense of failure.

Equally important is that many activities parents are asked to carry out cannot be simply incorporated into their daily lives, but are an additional parenting task. This goes against the central tenet of family-centred intervention, that activities should be embedded in the everyday business of family life. Carrying out the activities with children is not a simple process. It requires patience and flexibility on the part of the parents. Parents often have to prepare the activity and the context in which it occurs, and then adapt the activity and context in response to the child's level of engagement. All of this can be complex and time consuming. And if the response of the child is negative (which it often is) then the experience can be thoroughly demotivating for both parties.[4]

Sharing the process

Families commonly value relationships with competent and skilled professionals as the most significant factor in service coordination. Knowledge of relevant community resources, and an ability to help the parent learn about their child's development and how to meet their children's needs are seen as key (Dinnebeil and Hale, 2003). Significantly, parent satisfaction with interventions services is commonly dependent on their sense that they have been listened to. It is not just a matter of resources being provided, but about resources being those which satisfy the needs of the family. Practitioners often interpret parental requests for solutions as problem descriptions, and think that the problem will be resolved when the solution is provided. The parents often talk about a lack of resources or known intervention methods rather than the problem they are intended to resolve. The advice or the

[4] You could try the fourth activity for this chapter at this point – it can be found at the end of the chapter.

support practitioners provide can be well-intentioned but not what was needed (Carlhed, Bjorck-Akesson and Granlund, 2003).

Support is most effective if it has been requested (Bailey and Simeonsson, 1988; Dunst, Trivette and Jodry, 1997). Professionals should, therefore, not give advice unless parents ask for it (Carlhed et al, 2003). This is problematic, of course. Parents generally want and need as much information as possible, but if they are not asking the right questions then practitioners cannot tell them what they need to know. When faced with a situation like this, you need to help the parents formulate the questions they need to ask. To do this effectively trust must be established. Practitioners should seek to understand families' expectations about early intervention and what is feasible and what is not (Dinnebeil and Hale, 2003). It is about enabling families to own the intervention process. In the broadest sense this requires families being central to the setting of goals, the implementation of change and the assessment of the outcomes. This includes the identification of 'meaningful outcomes' for children and 'positive outcomes' for families (Dinnebeil and Hale, 2003). Families need to recognise their active agency (Bruner, 1996) through their initiation, completion and evaluation of the programme.

Within the family, individuals do not respond to the child, the services and situations in the same way. Fathers tend to deny the issues for longer, are more likely to bury themselves in practical matters, and if they have less contact with the child are likely to take longer to adapt (Orphan, 2004). Fathers are far less likely to be the recipient of support services, too. To many it will feel as if their needs are of secondary importance and that they are expected to cope on their own. Their understanding of the early intervention process also may be second hand, communicated through their partner. Of course, in many families the roles may be reversed or shared. In very busy families, the practitioner may have to be prepared to relay information between the parents, or repeat and clarify information for both partners.

It is not just the parents who are affected by early intervention activities. Siblings can find themselves drawn into the process. By paying attention to the situation of siblings practitioners can help them feel more involved (Atkinson and Crawforth, 1995). This is particularly significant as siblings will often spend longer with each other than with parents (Lobato, 1990). Their interactions also present a multitude of learning opportunities for both parties. Many studies have shown that elder siblings, in particular, can play a positive role in early intervention strategies (Hancock and Kaiser, 1996). However, the impact of the relationship works both ways and can have a variety of effects, both positive and negative. It is common to find siblings having to deal with feelings of love and affection, alongside contradictory feelings of isolation, jealousy, frustration and anger (Atkinson and Crawforth, 1995). Siblings have a tendency to worry about their brother or sister, and to feel protective about other people's responses to them. They witness the battles that their parents go through with service providers and within the community, as well as the support and friendship that is offered. They are aware of the emotional and psychological stresses and everyday practicalities that impact upon parents – their concerns must often play second fiddle to these. They too can be victims of teasing and can suffer guilt at perfectly reasonable negative feelings towards their sibling. They have to cope with restrictions upon family activities and the awkwardness of the responses of others (Lobato, 1990). Perhaps it is not surprising, given the degree of understanding they must demonstrate, that they tend to be well-adjusted and demonstrate a

maturity and sense of responsibility beyond their years (Dale, 1996; Seligman and Darling, 1989). [5]

Assessment

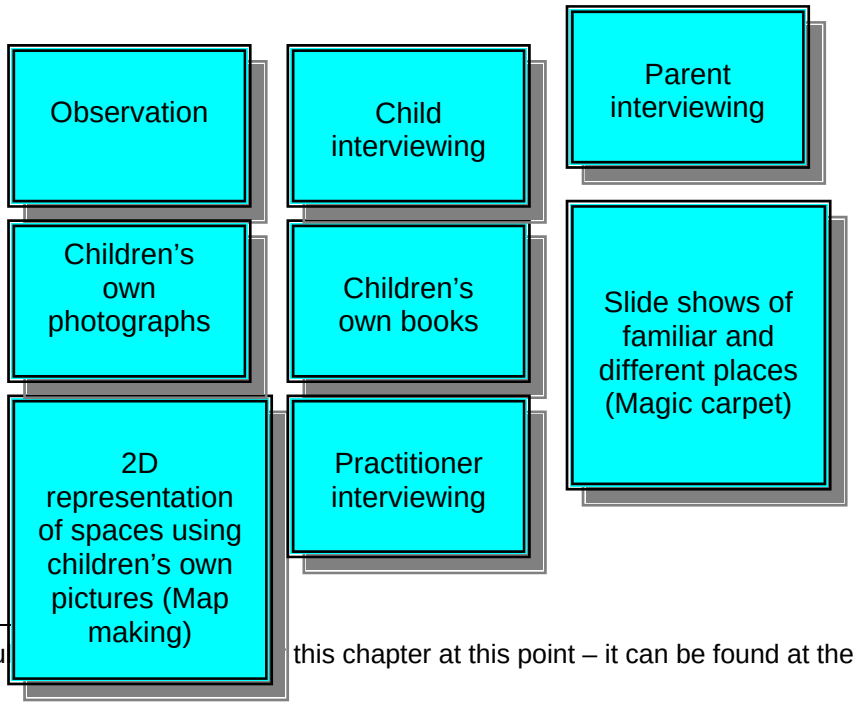
The Narrative Model

Up to this point there has been little discussion of the child with an impairment at the centre of the early intervention. The views and values of this individual are, of course, as important as any other member of the family, if not more so. Within much early years practice it is now widely accepted that to encourage a child to engage with their own development, practitioners must begin with the child's interests. Parents, too, recognise that children gain most from those early intervention activities which they enjoy (Rix et al, 2005).

> "Current views of children's learning suggest that those interests most likely to extend, deepen and improve their understanding of their own environments and experiences are most worth strengthening during the early years." (Katz, 2002, p149).

Gaining access to these views and values can feel even more of a challenge considering the age of the individual concerned and the likelihood of communication difficulties. Overcoming these difficulties to gain access to the child's perspective should be a central part of the assessment process. However, to do so requires observing the child 'in action', and recording and interpreting their interactions with others. When you explore the actions of the child in context and across time, coming to understand their meaning and purpose through discussion, then you are engaging in 'narrative assessment'. Your focus is not upon the child in comparison to others, but upon the child's individual ways of doing things and their motivations within the social, cultural and physical context. The Mosaic Approach is one way of developing a 'narrative assessment' with young children, in which the child takes the lead (Clark, 2005). This involves a variety of assessment methods:

Means of assessment using the Mosaic Approach



[5] You cou this chapter at this point – it can be found at the end of the chapter.

Another technique is ‘learning stories’ (Carr, 2001). These are stories written through an individual’s parental or professional filter, which focus on the child’s interests and strengths as a learner. Cullen, Williamson and Lepper (2005) report on an early intervention team who used this approach and found that it encouraged collaboration between the early intervention team, and had a positive impact on their views of the child. One hospital based professional, for example, noted that she was forced to document ‘the positives’, whilst a speech and language therapist felt it provided the “opportunity to set more realistic goals involving different disciplines.” (Cullen et al, 2005, p6).

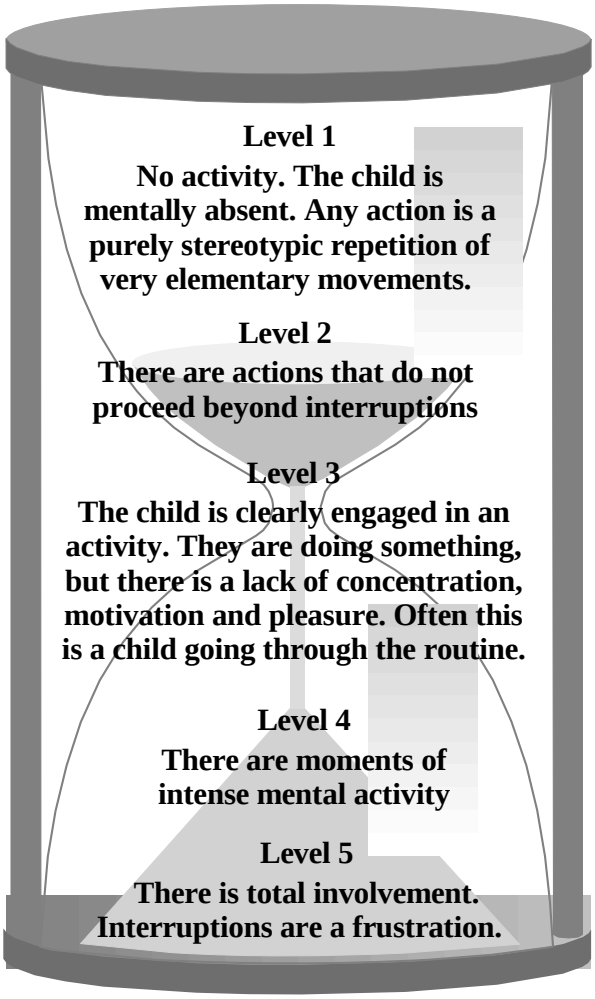
Since many early intervention strategies rely upon the agreement of the child, it seems essential that you understand their knowledge, skills, dispositions and feelings (Katz, 2002). Insight in the last two areas is best achieved through narrative assessment. Carr (2001) identified five dispositions. These can each be seen in the context of the child’s readiness, willingness and ability to learn, whatever their age.

1. **Taking an interest** – this keeps the child engaged. When they lose interest their attention is likely to wander.
2. **Being involved** – children will be involved if it is relevant to them, if they have the opportunity to have control over what is happening, and to lose themselves within it.
3. **Persisting with difficulty or uncertainty** – if children are striving towards goals of interest they are more likely to persist. If they are not of interest the persistence will lessen. It is easy to make a child rely upon the supporter rather than themselves through inappropriate support or activities.
4. **Communicating with others** – children have memories from their earliest moments, but it is through interactions that draw on these memories that meaning, understanding and organisation of thought can take place.
5. **Taking responsibility** – this allows children to make choices, to recognise that actions and decisions have consequences they control.

Key to the child dispositions is their feelings towards them. If a child does not feel they have or are able to have these dispositions, or they feel they will not be acknowledged or be allowed to use them, then they are unlikely to develop or demonstrate them. As practitioners you need to assess when a child is ready to demonstrate this disposition, is willing to demonstrate it and is able to demonstrate it.

A valuable assessment model in assessing the child’s feelings towards their situation and learning is the Process-Oriented Child Monitoring System (Laevers et al, 1994, 1997). This is used in many early years settings, and focuses on two major indicators – well-being and involvement. Practitioners screen children with a five point scale for each indicator. When a child falls below level 4, practitioners proceed with further observations and analysis (See following diagram).

The Leuven Involvement Scale (Laevers et al, 1997)



When evaluating the five levels of involvement and well-being, practitioners can consider the following signals:

Involvement

- Concentration
- Energy
- Creativity
- Facial expression and posture
- Persistence
- Precision
- Reaction time
- Language
- Satisfaction.

Well-being

- Openness and receptivity
- Flexibility
- Self-confidence and self-esteem
- Being able to defend oneself and self-esteem
- Vitality
- Relaxation and inner peace
- Enjoyment without restraints
- Being in close contact with one's inner self.

These evaluations focus upon the process of learning. They are about the child's engagement with their learning and learning environment. The resolution to difficulties lies in changing the context and not the child.

A similar ethos underlies the *Birth to 3 Matters* framework (DfES, 2002) for early years carers. This framework identifies four aspects of development – A Strong Child, A Skilful Communicator, A Competent Learner and A Healthy Child. These

aspects focus upon the strengths of the child and the interconnectedness of growing, learning and developing within a caring environment. Integral to approaches such as these, which place the child's experience at the centre of the assessment process, is the ability of the observer to get inside the experience of the child and to empathise with their feelings. Similar sensitivity will help practitioners to identify which different activities, environments and contexts are best suited to the child, and allow them to maximise their knowledge, skills and dispositions, so that they can best engage with the opportunities available to them.

The Developmental Model

Understanding the child's perspective is not a key issue when applying the developmental model of assessment. The Developmental Model identifies the typical order in which certain aspects of the child become evident. It breaks down the process into constituent parts, on the basis of statistical likelihood, and then measures the child against those parts. By doing this those aspects of the child that are developing more slowly than the statistical norm can be focused upon for therapeutic or early intervention. This Developmental Model underpins the Portage checklist and the range of Early Support materials that are designed to be family-held and to track the development of their child. It also forms part of the Early Years Foundation Stage and underpins many of the assessment and recording procedures of all professional groups. There are literally hundreds of assessment tools available to professionals. Below are some examples from the 18 categories measured in the *Monitoring Protocol for Deaf Babies and Children* (DfES, 2004).

Communicative behaviour	**Vision**	**Vocalisation**	**Self-other awareness**	**Motor coordination**
• Recognises and will identify many objects when named by speech • Picks out two or more objects from a group of four, eg 'give me the cup and doll', 'where's the…?' • Understands simple questions and directions without accompanying gestures, eg fetch the shoes	• Shows sustained interest in looking at pictures/ books with adult • Can scan quickly so trips over objects less often	• Talks to self continuously when playing, although this may not be readily understood by adults • Produces over 20 words with the correct meanings and increasing accuracy in pronunciation	• Will pause and wait for turn • Seeks to be the centre of attention • Recognises familiar adult in picture	• Runs without bumping into obstacles • Squats • Walks up and down stairs, holding on, putting two feet on each step

There are numerous developmental assessment tools available to a wide range of practitioners. These often require the practitioner to make value judgments based on personal and professional experiences, and to carry out a measurement process in a context in which the child does not typically function. Clearly, this out of context assessment does not always accurately represent the child's capabilities. This is why the Early Support materials recognise the importance of parents' views and observations in completing assessments.

Even when focusing on a similar aspect of development these tools can take quite different forms or have different descriptors. Consider the assessment of standing using two such scales:

The Bayley Motor Scale (BMS)
Part of the Bailey Scales of Infant Development. These also include a Mental Scale and a Behaviour Rating Scale

Aim: To assess the performance of activities against age related norms. The BMS focuses upon a general description and links this to a typical age range.

'Supports Weight Momentarily' in BMS.
The instructions fill a long 5 sentence paragraph
There is only one factor to consider.

The Alberta Infant Motor Scale (AIMS)
Used to measure gross motor maturation of infants from birth through the age of independent walking.

Aim: To assess the neuromotor system in different physical contexts, as the child moves into and out of 4 positions: prone, supine, sitting, and standing. The AIMS focuses more on the typical detailed movements of the body in carrying out an action

'Supported Standing' in AIMS
The instruction is a simple, single sentence
The Key Descriptors require the assessment of 10 factors.

Different practitioners come to feel more comfortable with different scales, partly out of professional necessity and partly out of personal preference. This does not mean that any of these scales give a truer picture of the child. Just as no child perfectly matches the norm, so no single scale can perfectly describe a child's development. They measure an aspect of the child, giving a snapshot or series of snapshots. They do not show the child themselves nor the child in context. Their main intention is to help practitioners to diagnose specific problems within the child and to identify activities or interventions that will remedy or minimise the specific problem.

The Functional Model

In an attempt to contextualise developmental assessment, there are a number of assessment tools that support the practitioner in assessing the child's development and functioning in everyday settings. These also require the professional to make value judgments and to judge the child against typically developing peers. Some of these functional assessment tools make it easier to take the child's views and interests into consideration. For example, the LV Prasad-Functional Vision Questionnaire (Gothwal, Lovie-Kitchin and Nutheti, 2003) asks slightly older children with a visual impairment to self-assess their functional ability in relation to such activities as: locating a ball, differentiating between colours, locating dropped objects, climbing stairs, differentiating between genders, applying toothpaste to a brush, and locating food on a plate.

The Abilities Index (Simeonssen and Bailey, 1988) is another tool that examines the child within everyday contexts. This requires practitioners to rate the child's physical, social, cognitive and communicative abilities – such as those listed below – in everyday activities:

Audition	Left ear
	Right ear
Behaviour and social skills	Social skills
	Inappropriate behaviour
Intellectual functioning	Thinking and reasoning

Limbs	Left hand
	Left arm
	Left leg
	Right hand
	Right arm
	Right leg
Intentional communication	Understanding others
	Communicating with others
Muscle tone	Degree of tightness
	Degree of looseness
Integrity of physical health	Overall health
Eyes	Left eye
	Right eye
Structural status	Shape, body form and structure

This index also draws on the professional notions of what is normal, in that it uses a scale of 0 to 5, with 0 indicating normal ability, 1 indicating some questions about the child's ability, and 5 indicating extreme or profound impairment. In making each rating, the practitioner is again asked to contrast the child to same age peers.

This notion of function in comparison to peers is also at the centre of assessment of autistic spectrum disorders (ASD). There are a number of functional assessment checklists that are available to evaluate ASD, such as: Childhood Autism Rating Scale (Schopler, Reichler and Renner, 1986), the Vineland Adaptive Behaviour Scales (Sparrow, Balla and Cicchetti, 1984) and Autism Diagnostic Observation Schedule (Lord et al, 2000).

The National Autism Plan (NIASA, 2003) draws upon the World Health Organisation's diagnostic criteria for childhood autism. This identifies a child with ASD on the basis of their failure to demonstrate:

- ⇨ Receptive or expressive language as used in social communication;
- ⇨ And/or the development of selective social attachments or of reciprocal social interaction;
- ⇨ And/or functional or symbolic play.

These factors are evidenced through the failure or lack of some of the specified reciprocal social interaction and communication markers and the presence of some 'restricted, repetitive, and stereotyped patterns of behaviour, interests, and activities'. Once again, professional judgment (or in the case of the Vineland Scales, professional and parental judgment) is at the core of these assessments. It is hardly surprising, therefore, given the scope for uncertainty, that there are many cases of disagreement between service providers and parents. Many parents recognise the need to have a diagnosis for their child so that they can gain access to support[6].

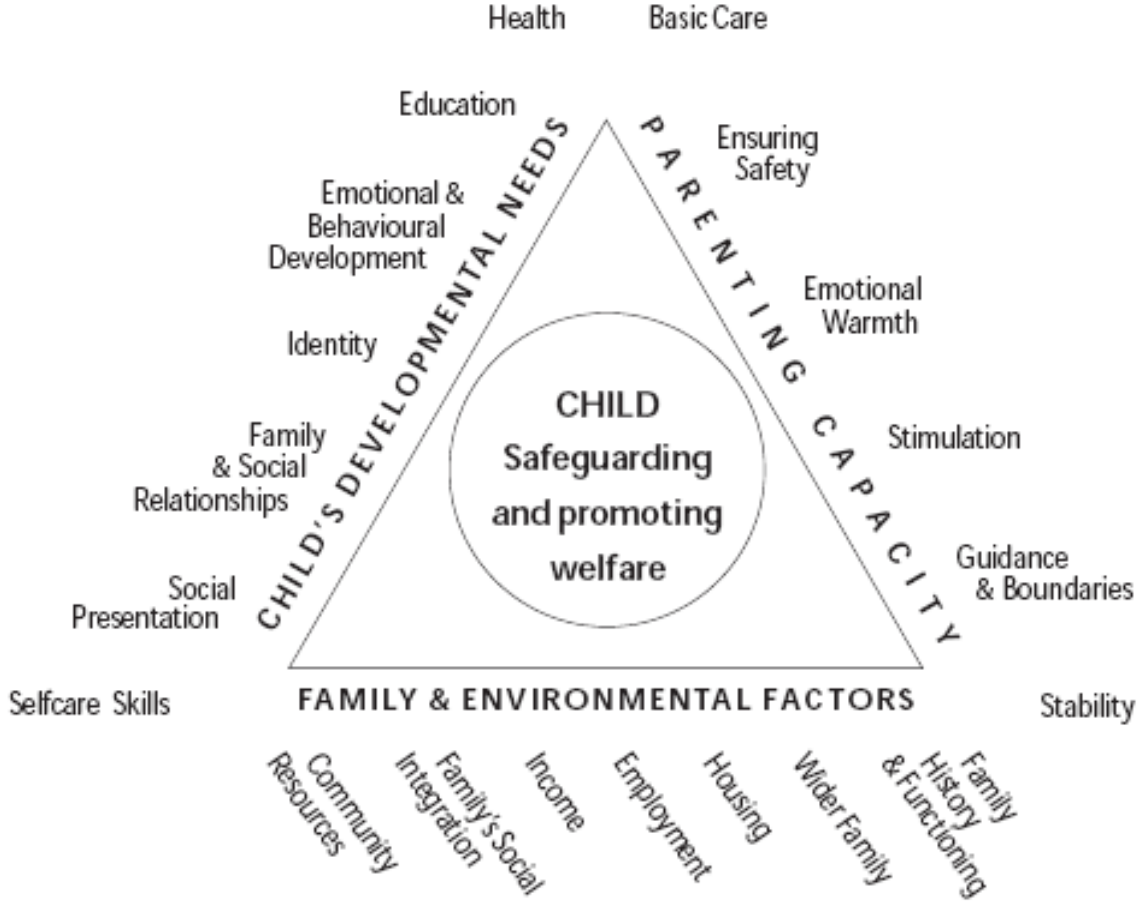
The broad view of the child

No one model of assessment enables you to develop a broad view of the child. To develop a broad view, a broad range of approaches must be taken. In 2000, the Department of Health produced an assessment framework that reflects this need to examine the child holistically. This presented a child-centred view, which examined the child's developmental needs, family and environmental factors and parenting

[6] You could try the sixth activity for this chapter at this point – it can be found at the end of the chapter.

capacity. It identifies the full range of considerations that social services must engage with, if they wish to identify both the child's needs and the barriers to their development and support.

The assessment of children in need and their families



(Department of Health, 2000, p89)

This broad view of the child is reflected in the Common Assessment Framework[7] which began to be introduced in 2005. The aim of this framework is to produce a national standardised approach to the assessment of the strengths and needs of a child and the decisions about how those strengths can be built upon and those needs can be met. The intention is to use early intervention to minimise or eradicate the problems that families and individuals face, rather than leaving it till later when the consequences of inaction are evident. It is also hoped that it reduces the number of assessments families have to undergo, promote information sharing and unify language across services and ensures that children have the best possible chance of meeting the Every Child Matters five outcomes.

In making the rich and broad assessment of the child, practitioners need to directly work with the child, their parents, their family and other caregivers. Department of Health recommendations (2000) highlight the need to play with and carry out other shared activities with the child, as well as conducting interviews and questionnaires with them which are age and culturally appropriate. It is also important to take parental and family histories, and to develop a shared view of parental, family and

[7] See Early Support distance learning text chapter by Paul Gutherson and Liz Pickard – I*nformation sharing, the Common Assessment Framework and Early Support* – for more detail on the Common Assessment Framework and its relevance to Early Support.

community issues and resources. Selective use of specialist assessment and scales is also recommended as is the use of the views of other practitioners who have worked with the child and family over time. Of key importance too, is the observation (including the use of video and audio recordings, and written notes) of the child within a variety of family and community contexts, and the revisiting and re-reading of this material when discussing and planning with families. This is a process that should be carried out across time in an ongoing, flexible and manageable way. It has to fit in with the lives of the family and run alongside the hands-on activities that are at the heart of early intervention.

Reflecting on you and your practice

Technical rationality and praxis

The belief that professional training must begin with generalised, systematic, theoretical or scientific knowledge is called 'technical rationality'. This belief gives superior status to the individual who has ownership of that knowledge and even greater status to those who can theorise and deepen that knowledge. The problem with this is that taught knowledge is not always easily applicable or relevant to the circumstances in which you work.

> "In real-world practice, problems do not present themselves to the practitioner as givens. They must be constructed from the materials of problematic situations which are puzzling, troubling and uncertain." (Schön, 1983, p40).

There is a real danger that we highlight this taught knowledge at the expense of on-the-job experience and other personal knowledge – as well as the individual circumstances of a family. To minimise this risk, and maximise the use of all available knowledge, practitioners need to be reflective…and parents will find it valuable, too!

The key to reflexivity is 'praxis'. Praxis is the process of questioning your actions through the lens of your theoretical and personal knowledge. It is about "revising and refuting action on the basis of reflection." (Fletcher, 1999, p159).

Understanding the basis for your reflective practice

The key aim of reflexivity is to develop a deeper understanding of your own views and ways of working and behaving, the context in which you are operating, and the perspective of others. This involves reflecting on the techniques and concepts which you are applying to a situation and the cultural and moral assumptions that underpin their application. This allows you to construct new, more appropriate, ways of applying your skills and developing your professional and personal knowledge. As a consequence you should be able to avoid impulsive or routine actions that are not responsive to the context.

You need not feel that in trying to understand a situation or describe it, that you are striving for a complete or entirely faithful representation. You are developing a perspective that allows you "to produce new actions that improve the situation or trigger a reframing of the problem." (Schön, 1983, p277). You cannot understand everything! But you **can** identify possible routes to better practice, possible barriers to engagement and possible means to overcome them.

Such reflection can occur both in the moment and over longer periods of time. It can be both an internal, self-analytic act and an external one involving discussion with others. These others may be within the family, or include the child concerned or professionals with whom you work. It requires identifying opportunities to reflect on what is going on within the given context. With practise, identifying these moments becomes part of the routine process of your day-to-day working life. At times, it is possible that this reflection can produce unintended changes or even alter practice for the worse. But this should be a short-term diversion on the way to long-term improvements. Unintended changes may give a new meaning to the situation, but through engaged listening, you can appreciate the new meaning and reframe once more. Schön describes this process of appreciation, action, reappreciation as an 'appreciative system'.

In exploring your perspective there are constants with which you can begin. Schön identified the following:

1. The tools, languages and methods that you use to describe reality and conduct assessments and appraisals.
2. The appreciative systems that you bring to problem setting, to the evaluation of inquiry, and to reflective conversation.
3. The overarching theories by which you make sense of phenomena.
4. The role identity within which you set your tasks and through which you are bound to your institutional settings[8].

The role of listening and understanding values

A central aspect of reflective practice is listening. As a starting point you need to be active listeners. Active listening encourages the speaker to engage more fully in the communication. It requires that you show that you are listening. Typically, in the UK, active listening would involve giving full attention to the speaker, allowing the person to finish what they want to say, and focusing on them physically and intellectually.

Within different cultures and contexts, of course, there will be different visual and verbal cues that encourage engagement (eg giggling when being tickled). As discussed in Chrissy Meleady's chapter[9], your cultural and social values and roles can act as barriers to your communications with others. Kondrat (1999) suggests that to overcome these barriers practitioners need to ask questions about 'the world'; about 'my world'; and about correspondences and contradictions between those worlds (p465). Because of the power-knowledge axis it is important to consider the imbalances between these worlds. It is important to ask how your actions might contribute to unequal outcomes for different individuals. This requires questioning your conscious intentions with different individuals from different socio-economic and cultural groups and the different impacts that your intentions have upon them.

It may be that your intentions for each individual are the same, but that the outcome is different. It is essential, therefore, to examine the gap between your intentions and the outcomes as evidenced by the individual. When coming to an understanding of the individual's response to your involvement, it is sensible to question the degree to which this individual is typically marginalised by social systems. By understanding this, you are better placed to question whether their behaviour is a result of previous

[8] You could try the seventh activity for this chapter at this point – it can be found at the end of the chapter.

[9] See Early Support distance learning text chapter by Chrissy Meleady – *Equality and diversity* – for more discussion on culture and social roles.

marginalisation and/or resistance to further marginalisation. Through such reflective action it may be possible to break a cycle of inadequate provision.

In exploring the impact of your power within a relationship it important to identify your subject positions (Heron, 2005). This requires considering the external experiences and influences upon an individual that shape and inhabit their understanding of their situation and the wider context. Drawing upon Heron's work you can consider the following questions:

- ⇨ What are the power relations operating here?
- ⇨ What subject positions do I occupy?
- ⇨ What subject positions does this other individual occupy?
- ⇨ How are we both 'empowered' and 'disempowered' in this relationship?
- ⇨ What and how are we both resisting – personally and within a wider context?
- ⇨ What value and effort do I invest in understanding how to provide equal service to all?
- ⇨ Why do I invest this level of value and effort?
- ⇨ How does this investment act as a barrier or facilitator for the families I work with?
- ⇨ What self-image do I have as a result of my good intentions towards different social/ethnic/cultural groups?
- ⇨ What will happen to my self-image if I see myself as having failed in respect to my good intentions?
- ⇨ Have I failed? Have I, in fact, been unequal in my work with these individuals?

The intention of questions such as these is not to berate yourself. They are a means of examining and challenging your unspoken biases and those which exist within the systems around you, and of identifying factors from which you and others can learn.

Reflecting on your early intervention with the child

Much of your reflexivity will involve consideration of the child and your early intervention in the context of their home life. Central to this analysis is your recognition that the child is neither a static entity nor a passive one.

> "Disabled children, whatever their impairment, can be competent participants in every day decision making processes when… their participation is properly planned and not reliant on short-term adult assessments of competency, and when they are able to work with reflexive adults. By this, we mean adults who understand that disabled children, like other children and adults, are flexible social beings whose behavioural patterns, communication abilities, level of involvement and level of interest will vary over the duration of an activity." (Davis and Watson, 2000, p213).

Susan Hart (1996) recognised that much is overlooked that can enhance learning because people are looking for the things that get in the way of the learning, or for things that they believe can be improved. She felt that you need to consider your actions and experiences not because it is the source of difficulties but because it is a "source of insight into possibilities." She called this reflexive process, 'innovative thinking'.

In trying to understand the learning situation Hart realised that she needed to consider as many perspectives as possible. She recommended:

- ⇨ **Making connections**: Attempt to understand how the child's response is affected by their environment and experience and in what ways these can be influenced by the practitioner.
- ⇨ **Contradicting**: Attempt to create a legitimate contradictory reading of the child's response, revealing the underlying assumptions that make us see a child's response as problematic.
- ⇨ **The child's eye view**: Attempt to see in what way the child's response is active and logical from their perspective.
- ⇨ **The impact of feelings**: Attempt to understand in what way our interpretation of the child's response is a consequence of projecting our own hopes and fears.
- ⇨ **Suspending judgement**: Attempt to stand back from the analysis, and question to what degree the information you have is enough for the actions you are taking.

The importance of taking this innovative thinking approach is that it includes the context. The child is not the sole focus. You are led to explore other possibilities beyond your traditional response. This provides you with a greater degree of autonomy, but allows you to acknowledge practical requirements and constraints. Of course, such an innovative approach can work just as well in other contexts, should you need to shift the focus of your thought from the child to the parent, a fellow professional or even yourself[10].

Conclusion

Within this chapter you have been critically examining your role and practice. You have considered the nature and power of your knowledge, its impact upon families and the need to draw upon their understandings. You have had an overview of forms of assessment across the professions, and considered their strengths and weaknesses in the context of your working life and in relation to the sorts of outcomes they produce. You have also explored the importance of being a reflective practitioner and looked at techniques to help in this process. Underlining the whole chapter is your need to question and examine assumptions and ways of working. The rationale for this emphasis is well summed up by Micheline Mason:

> "Professionals act within a system, backed up by laws, regulations, colleagues, resources, training, status, clerical support, large offices, long words and emotional distance. Parents only have their love for their child, and their desire that that child should be given the best possible chance to have a good life. How is partnership possible in such an unequal state of affairs? It is only possible if everyone involved is willing to examine the values and beliefs which lie behind all our actions." (Mason, 1996).

At heart of the chapter are the tensions between the needs of assessment, provision and the family. When you are trying to strike a balance between these tensions you may find the following questions from Podmore and Carr (1999) of particular use. They should help to focus you back on the person at the centre of it all, the child.

- ⇨ Do you know me? Do you appreciate and understand my interests and abilities and those of my family?
- ⇨ Can I trust you? Do you meet my daily needs with care and sensitive consideration?

[10] You could try the final activity for this chapter at this point – it can be found at the end of the chapter

- ⇨ Do you let me fly? Do you engage my mind, offer challenges, and extend my world?
- ⇨ Do you hear me? Do you invite me to communicate and respond to my own particular efforts?
- ⇨ Is this place fair for us? Do you encourage and facilitate my endeavours to be part of the wider world?

Activities

What follows are eight activities that relate to the topics raised in this chapter. These activities support your learning in this area and you should consider using these activities to support your reflective diary entries.

Activity 1: Groups

Use the format of the table below to write a list of the different groups of which you are a member and for which you have different forms of knowledge. Make notes about how important the knowledge you have is in the context of different groups. Also consider to what degree you value the different forms of knowledge that you have and how having these different forms of knowledge makes you feel about yourself. (**Comment:** The author identified some of the following groups.)

Groups I am a member of	**Primary knowledge**	**Value of knowledge to other groups**	**Value of knowledge to myself**
Teaching profession	Pedagogy theories School system English as an additional language How to listen How to simplify	Useful as parent Useful as academic Useful as parent of child with Down syndrome	Confidence in class Confidence with other professionals
Parents	How to show feelings How to organise How to be a role model	Useful as parent of child with Down syndrome Useful as teacher	Helps me feel I am doing my best (though failing at times) Motivation to do things
Parents of child with Down syndrome	Some understanding of the syndrome Parent networks The support system Sign language	Useful as parent Useful as teacher Useful as academic	Confidence with professionals?? Confidence and motivation in carrying out early years activities
Academics	Theories People network Academic systems Critical thinking How to research and write	Useful as parent Useful as teacher Useful as parent of child with Down syndrome	Confidence in the breadth of my knowledge Confidence with professionals?? Uncertainty about past teaching and parenting practices
Rock music fan	Names of bands How to dance without caring that I look a fool	Useful as parent?? Useful as chat material??	I have not entirely lost touch with my past

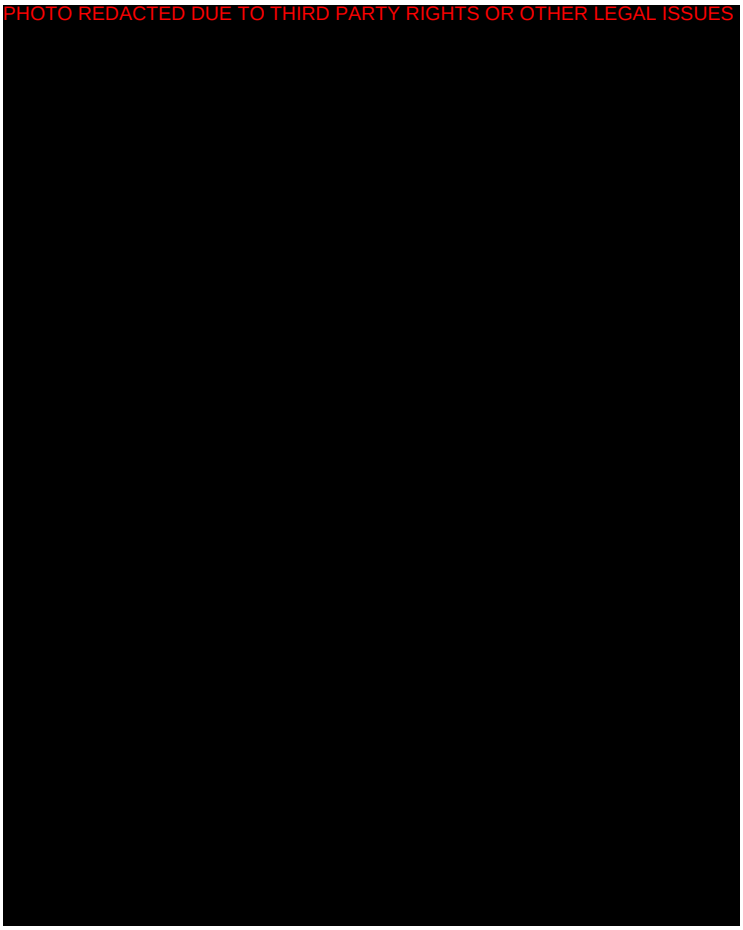
Activity 2: Working sensitively with the family
Read the following description and consider some of the factors that you would need to take into consideration to work sensitively with the family's situation:

> Vijay is 3 years old and has Spina Bifida and hydrocephalus. He lives in a ground floor three-bedroom flat. He enjoys being with his two older brothers and gets frustrated when he cannot play with them. Vijay has long leg braces and can use crutches, but walks for exercise only. He needs a wheelchair for most activities and also has a shunt to relieve fluid build up. Vijay occasionally demonstrates a number of disconcerting behaviour traits, and seems to have a poor short-term memory. His parents feel he communicates better in familiar settings, but loses confidence in unfamiliar settings. However, his mother feels she has difficulty understanding a lot of his wishes.
>
> Vijay's parents feel overwhelmed by the number of services they must access for their son, and are not fully aware of the support that is available to them. They do not feel confident with official paperwork such as the Disability Living Allowance. They both have to work, and struggle to juggle the mother's part-time work and the father's full-time job. They rely heavily on Vijay's grandmother who speaks Gujarati and a little English. They do not wish to ask for help from others, and like to keep Vijay at home as much as possible, where they feel he is safe.

Comment
You probably identified time pressures as a key issue, in relation to carrying out early intervention activities, conducting meetings and accessing services. It would also make it harder for the three carers to communicate about events and issues in relation to Vijay. The small living space may also cause the family problems, but the parents' desire to keep Vijay in the domestic setting may suggest that this is something they are at ease with. This belief that Vijay does best in the safety of his home may have a bearing on the activities the family wish to engage in, and the sorts of services that are appropriate for them. Making them see the value in Vijay's engagement with the wider community has to be handled with great sensitivity, as does the provision of any respite care or home support that you might feel is appropriate. It would be a mistake to assume that the parents are nervous about Vijay's behaviour in public, though discussing this issue with the parents would be important. The key relationship that Vijay has with his brothers may help to serve as a platform for wider engagement, but it would be important not to place too much pressure upon these siblings. The grandmother's limited English may act as a barrier to your communication skills, but it means that Vijay is developing as a bilingual language user. This may have a bearing on any additional support you identify as necessary and the form it takes. Cutting the grandmother out of the consultation process could be both a missed opportunity and a slight on her skills.

A key factor in the above analysis is the focus of concern. In considering how best to support Vijay through his family no consideration has been given to Vijay's identified impairments. Identifying how we can best support Vijay does not start with these impairments but the context in which he has to operate. This assumes that individuals are not primarily disabled by their impairments, but by the failures of those around them to respond to and support them in best living with those impairments.

Activity 3: Reactions
Look at this picture and write down your immediate first thoughts:



http://www.our-kids.org/OKPics/felix_superman.jpg – accessed 13 January 2006

Comment
You may have initially identified a child with nemaline myopathy, in a wheelchair, with a throat tube, and with under-developed legs. Of course, when the boy, his family or friends look at the picture, they initially see a young lad having fun at the bowling alley and pulling off his top to reveal that he is Superman. Seeing the impairment first is a problem that we all have to struggle with. Professional knowledge encourages us to focus on the impairment. Practitioners need to take every opportunity for celebrating a child as they see themselves and as their families usually see them, rather than framing them through the professional lens.

Activity 4: Social stories
A common activity given to parents or carers is to create a social story book to help with language or social development. This may contain pictures of the child, family and friends carrying out activities, with captions underneath. Creating such a book seems a simple task. Use the headings shown in the following table, complete each column listing the actions required in creating this book, the problems that may be faced in carrying out those actions and the time you would expect all this to take.

Making a Social Story Book		
Action	**Problems potentially faced**	**Time taken**

Comment
You probably recognised four actions involved in making the book: choosing a book or finding plain paper, choosing pictures, writing labels, and sticking pictures and labels in the book. There may be no book or paper in the house and these may need to be bought. Then the parent will have to take photos, creating time and cost issues. There may be no computer in the house for the labels, difficulties over choosing the best font or poor handwriting. Parents or carers may also worry about how best to lay out the book or lack the appropriate glue or sticky tape in the home. At the best this job will take about one hour to complete, but at the worst it may take up to four hours. These hours have to be found within the day-to-day household and work-life of the parents and in the context of the time spent carrying out other early intervention activities. The parents also have to give additional hours to meeting with professionals. None of this would be expected for a typically developing child.

Activity 5: Siblings
Read the following description by Ayla, aged 9 and Amani, aged 6, of some of their experiences of living with their brother, Faris, aged 3. As you read make notes about the challenges and opportunities that their relationship presents and some of the opportunities for yourself as a practitioner.

> "Faris can't talk, but he can do a bit of sign language and he makes noises. He can't express his feelings, though, and that's why sometimes he hits people. We understand that more now, but other people – like our cousins – don't always understand that if he hits them, sometimes it's his way of saying, 'Come and play', because he can't express himself.
>
> "Faris is very playful. He's always smiling and never seems sad. He loves playing chase, and we play with balls with him. He goes to the nursery and he's very popular there – he's got lots of friends. We help Faris by playing with him and doing sign language. He has to get suctioned out to clean his tubes – we can both do that for him, but Dad has to do the hard things….
>
> "It can be hard for us, like sometimes when we want to play we have to play things with Faris instead. Sometimes we leave him out – not on purpose, but just because we want to do something for a while and he can't do everything. We can't go to a lot of places, like the cinema, with Faris because of his tubes." (Hames and McCaffrey, 2005, p38).

Comment
Among a number of issues, you probably noted the reduction in certain social activities, but also that Faris has access to other young people. You might also have considered the pressure on them to explain their brother's actions, as well as the variety of games they can play together, and their chance to develop a very useful second language.

As a practitioner you may have noted a number of speech and language opportunities, social and behavioural skill opportunities as well as opportunities to develop gross and fine motor skills.

Activity 6: Models – evaluation
Read the four statements below and make notes about the strengths and weaknesses of the Narrative, Developmental and Functional Models of assessment, answering the following questions:

- How does the model help with identifying physiological and cognitive impairments?
- How does the model help with identifying social barriers?
- How does the model help with identifying early intervention activities?
- How does the model impact on your view of the child?

1. ”The notions of ‘child development’ and ‘ages and stages’ are odd given the great variety of human life and experience.” (Penn, 2005, p7).
2. The purpose of using development models can be seen to be the simplification of contradictory everyday realities (Zuckerman, 1993).
3. Development involves the interplay of the resources of both the child and those within their environment (Sameroff, 1994).
4. “For the child whose profile mirrors what is seen in normal development, normative sequences (eg what might be taught first and what might be taught next) can comfortably be used as a reference point for intervention planning.” (Gerber and Kraat, 1992, p21).

Comment
In some ways all the models can identify the comparative weaknesses and strengths of a child, though the Functional and Narrative models give less detail about the nature of the impairment in relation to norms. This means they may miss some aspects of deviation, but such deviation may not be a cause for concern, or could be dealt with through changes to the environment rather than the child. While the Developmental Model is of particular use for physiological impairments that require a medical intervention, the Functional Model is more likely to help you identify social barriers, whilst the Narrative Model may also help you identify ways of overcoming the barriers. All three models can help in the identification of activities, but the Narrative Model is more sensitive to the child’s interests and motivations. All models carry with them a reminder of the child’s impairment, but the Developmental and Functional models are more likely to encourage you to focus upon them and less upon the child.

Activity 7: Understanding your professional framework
Make notes about the constants with which you operate. Use the following headings to help frame your thinking.

By carrying out this activity in detail you will provide yourself with a firm understanding of your view of the professional framework in which you operate. This will serve as an excellent foundation for developing your own reflexivity in action. It

should make the process easier! As a parent it will also help you to understand the manner in which your thinking about your child has been influenced by the professionals with whom you work and by courses such as this one.

1. Tools you use to describe and evaluate an individual and their context.
   - The language you use to describe an individual and their context.
   - Methods you use to describe an individual and their context.

2. Questions you ask yourself about your practice when you evaluate a complex issue or situation.
   - People with whom you evaluate a complex issue or situation.
   - Times and places you are in when you evaluate a complex issue or situation.
   - The theories you call upon when evaluating an individual, complex issue or situation.

3. Professional expectations of you when evaluating an individual, complex issue or situation.
   - Your professional and personal responsibilities when evaluating an individual, complex issue or situation

Comment
In carrying out this activity it is unlikely that you have identified every relevant factor. However, you have created a firm platform for further reflection. By bearing these ideas in mind, you will come to recognise additional factors and changes that take place to current ones. You will also find that you are better able to evaluate the impact of new factors that emerge from the changing family and professional environment.

As you carried out this activity you may well have identified a link between the factors that you have noted down and the different knowledge forms discussed in Section 1. In examining these constants you are also examining your workplace subject knowledge, your workplace practice knowledge, your workplace context knowledge and your personal knowledge construct.

Activity 8: Solution seeking
Read the following simple scenario and use the innovative thinking approach to explore what might be happening and possible solutions.

> Helen has been happily doing activities at the table with Jamie. The focus is language and speech development, which has been assessed as Jamie's primary developmental delay. As usual, though, when she gets out the sound cards Jamie knocks them from the table and tries to get down from his seat.

Comment
You may have considered the formality of the table as a problem, or the length of time he has been sat there. Perhaps the practitioner is giving some sort of cue of uncertainty before starting the cards. Maybe the child understands that he cannot do these sounds yet, and does not wish to waste his time. Maybe he finds them boring. Maybe the clear focus on his communication difficulties is too threatening to him. Maybe the child enjoys picking cards up off the floor. Maybe he is saying he wants to do the activity somewhere else. Maybe he recognises that his friends and siblings never have to do this type of activity and so doesn't see why he has to. Maybe he is

annoyed that Helen has not listened to his previous complaints about doing this activity or doing it in this way. Maybe Helen feels under too much pressure to make him use these sound cards as she has been taught that this is one of the best tools for developing sound production. Can Helen be absolutely sure that developing speech is the most important communication priority for the child? Maybe developing his signing skills would be of greater immediate value to him. Does Helen feel that this is a skill she can contribute to?

Asking these questions does not of itself produce a solution, but it does provide a variety of options for changing practice in the search for the solution.

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