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DOI:

[10.1080/02667363.2019.1567465](https://doi.org/10.1080/02667363.2019.1567465)

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*Document Version*

Peer reviewed version

*Citation for published version (Harvard):*

Edmondson, S & Howe, J 2019, 'Using solution-focused brief therapy within an eco-systemic approach to support return to school following an acquired brain injury', *Educational Psychology in Practice*, vol. 35, no. 3, pp. 243-256. <https://doi.org/10.1080/02667363.2019.1567465>

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# **Using Solution-Focused Brief Therapy within an Eco systemic Approach to Support Return to School Following an Acquired Brain Injury**

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# **Using Solution-Focused Brief Therapy within an Eco-systemic Approach to Support Return to School Following an Acquired Brain Injury**

## **Abstract**

This paper describes a therapeutic intervention within an eco-systemic approach in order to support a pupil's return to school following an acquired brain injury (ABI). The outcomes suggest that there were three key facilitative factors during the reintegrating of a child with an ABI back into school. These were supporting and educating school staff during the individual's reintegration, one-to-one therapeutic work with the individual and the psychological formulation of the individual's needs and strengths to support a personalised approach to their reintegration. This provides some preliminary support for the use of an eco-systemic model when EPs are undertaking therapeutic work in similar cases. However as this work is based on a single case study the findings need to be treated with caution. There is a requirement for further research to provide a more robust evidence base in order to determine the use of therapeutic approaches within an eco-systemic approach.

Keywords: educational psychology; therapeutic approaches; solution-focused brief therapy; eco-systemic; acquired brain injury

## **Introduction**

In 2007 MacKay suggested that the decline in the use of therapeutic approaches within educational psychology (EP) practice was about to be reversed (MacKay, 2007). He identified the rise in mental health problems in children and young people, the establishment of an evidence base for some forms of therapy and the re-examination of role of boundaries in applied psychology, as the contributory factors for this change. MacKay's (2007) paper has proved to be prophetic, as concern for how best to meet the mental health needs of children and young people has continued to rise and there has been a corresponding rise in the number of papers published by EPs, which focus upon therapeutic casework with both individuals (Atkinson & Woods, 2003; Atkinson & Ames, 2007; Atkinson, Corban, & Templeton, 2011, Hannen & Woods, 2012; Cryer & Atkinson, 2015; Cane, 2016) and groups (Kvarme, Aabø, & Sæteren, 2013; Weeks, Hill & Owen, 2017). MacKay (2007) attributed the decline in the use of therapeutic work to the call from the reconstructing educational psychology movement (Gillham, 1978) for educational psychologists to move from being individual case workers to taking a more systemic approach when working in

schools. In doing so he presented therapeutic work in juxtaposition to more systemic ways of working. However, more recent developments, notably the publication of guidance on the delivering of psychological therapies from the DECP suggests that good practice combines the use of therapy with a systemic approach in schools (Dunsmuir & Hardy, 2016).

Dunsmuir and Hardy (2016) suggest that when undertaking therapeutic work educational psychologists should ‘think about the child or young person within multiple systems’ (p. 6). They argue that the child or young person’s environment plays a crucial role in how their difficulties are shaped and maintained and can also support positive change. Therefore they suggest that ‘...actively working with the child as one element within the wider system is fundamental in the delivery of psychological therapies in schools’ (p. 7). To support this recommendation Dunsmuir and Hardy (2016) suggest an ecological model of development drawn from the work of Bronfenbrenner (2005) and Cicchetti and Lynch (1993) to help practitioners to draw upon both individual and systemic factors when formulating therapeutic work.

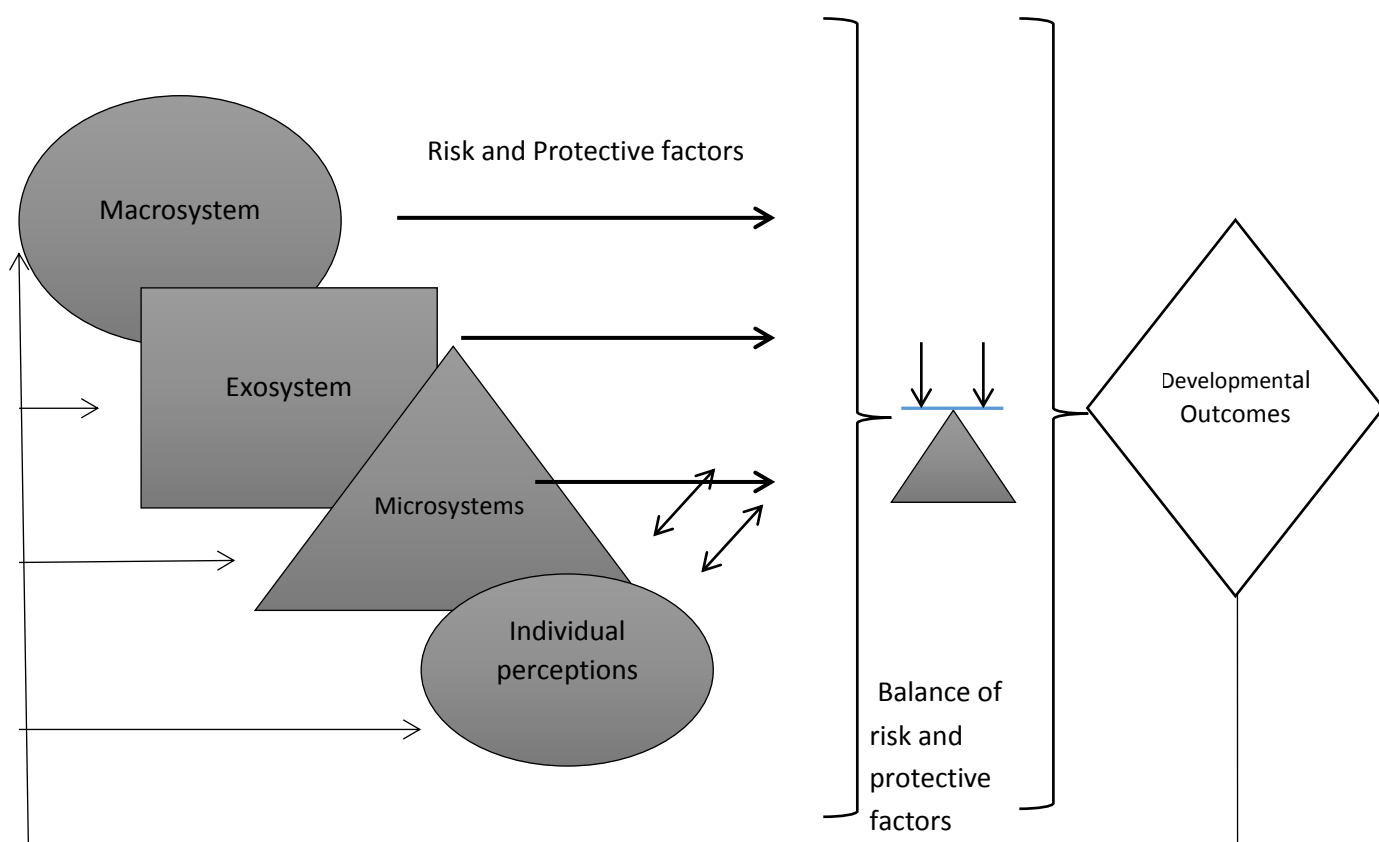


Figure 1: The Ecological Model of Development (adapted from Dunsmuir and Hardy, 2016)

Figure 1 here

Within the published literature on the use of therapeutic casework by educational psychologists references to the more systemic aspects of this work are scarce. An exception to this is a paper by Cane (2016) who provides an account of using a solution-focused and systemic approach to casework in a secondary school. Cane (2016) suggests that incorporating therapeutic work with a systemic approach promotes the idea that both the pupil and the school staff need to take responsibility for change. While Cane (2016) provides an account of work with an individual pupil reinforced by consultation with school staff she does not propose a model that can be used to support this work. This paper discusses the use of The Ecological Model of Development, as proposed by Dunsmuir and Hardy (2016) to reintegrate a pupil back into school following a long term absence after an acquired brain injury (ABI) with a particular focus upon the young person's ontogenic development and how this interacted with the microsystem (Cicchetti and Lynch, 1993).

### **Supporting the return to school for children and young people with an ABI**

The effects of ABI are often complex, affecting several areas of functioning and interventions need to address the multifaceted needs of children and young people as they return to school (Lindsay and Edwards, 2013). Children with severe ABI are likely to experience difficulties in intellectual functioning (Anderson, Catroppa, Morse, Haritou, & Rosenfeld, 2009) and a slower rate of progress with academic skills compared to their peers (Ewing-Cobbs, Barnes, & Fletcher, 2003; Hawley, Ward, Magnay, & Mychalkiw, 2004). Post injury cognitive impairments which can create a barrier to learning include sensory-motor difficulties (Davis and Dean, 2010) decreased mental flexibility, learning ability, reasoning, problem solving (Taylor et al., 2002) speed of processing (Anderson, Catroppa, Morse, Haritou, & Rosenfeld, 2005) language difficulties (Sullivan and Riccio, 2010), memory impairments (Lowther and Mayfield, 2004; Kizony, Tau, Bar, & Engel, 2014; Philips, Parry, Mandalis, & Lah, 2017)

and difficulties in executive functioning (Horton, Soper, & Reynolds, 2010).

Research suggests that children post ABI can have more behavioural and emotional difficulties (Noggle & Pierson, 2010). This may make their reintegration back into school more difficult and additional social and emotional support may be necessary to successfully return to school. They can appear more impulsive, prone to emotional outbursts (McClusker, 2005; Hawley et al., 2004), experience anxiety and depression (BPS, 2004), display aggressive behaviour (Hawley et al., 2004), have difficulties in attention (Catroppa, Anderson, Godfrey & Rosenfeld, 2011), impaired concentration (McClusker, 2005) and can seem withdrawn and lacking in motivation (McClusker, 2005). Severe ABI is also more likely to be associated with additional health problems such as tiredness, headaches (Hawley et al., 2004; Wilkinson et al., 2018) and post-traumatic epilepsy (BPS, 2004).

There are no agreed strategies or interventions to support children and young people returning to school with an ABI and many return with no support plan. In a systematic review of 17 papers evaluating hospital to school reintegration Lindsay, Hartman, Reed, Gan, Thomson and Solomon (2015) conclude that interventions for children and young people with an ABI tend to focus on individual behaviour and cognitive functioning, rather than on increasingly knowledge of the condition and family support. This intervention aimed to work at the individual level and also within the micro system of the school and family, with the aim of both supporting the pupil emotionally with his return to school while also working with his parents and teachers to repair relationships, and to increase their understanding of the effects of an ABI. .

### **Pen Portrait of Matthew**

At the time of reintegration Matthew was 15 years old, reaching the end of Year 9 and soon to go into Year 10. He had been in a collision with a car whilst riding his bicycle and had acquired a severe brain injury. Matthew spent four weeks in a specialist unit, followed by five weeks in a children's hospital. Having returned home Matthew briefly returned to school, he struggled to cope and was excluded due to aggressive behaviour. Following his accident Matthew experienced difficulties in his physical abilities, speech and language, memory, concentration, attention and emotional wellbeing. He struggled with fatigue and headaches and those close to him reported changes in his personality, including aggressive outbursts.

At the time of this intervention Matthew was physically well and his speech and language had improved to the point of being able to have a shared conversation. He agreed to take part in the individual work and seemed keen to return to school. Information gathered on Matthew indicated that he had been out of school for approximately 21 months. During this time he had been receiving home tutoring support from a local authority specialist provision.

Following his exclusion, communication between home and school broke down and discussions with Matthew and his parents indicated that they felt the school did not want him to return. Matthew explained that when he had woken from the coma he did not know who he was. He seemed to be rebuilding his identity at a time when he was surrounded by negative messages regarding his behaviour and he was anticipating negativity when he returned to school. He said that he wanted to return to school but did not know how or if he could. Matthew felt that things were out of his control and he was struggling to identify ways forward.

### **Ethical considerations**

The British Psychological Society's Code of Human Research Ethics (BPS, 2014) was used when conducting this work. Consent for EP involvement had previously been gained and verbal consent for the reintegration work was gained from both Matthew and his father. Before each session began Matthew was given the option of whether he wanted to attend the session and at the end of each session Matthew was given the option of meeting again. Mathew's identity has been protected by the use of a pseudonym throughout this paper.

### **Using a Solution Focused Approach at the Level of Ontogenic Development**

Cicchetti and Lynch (1993) define ontogenic development as the "...factors within the individual that influence the achievement of competence and adaptation." (p. 103). It was decided that the future focus of a solution focused approach was the most appropriate approach to support his return to school.

For adolescents, such as Matthew, who experience a moderate to severe ABI there is a high likelihood of their experiencing mental health and behavioural problems that can have an adverse impact upon their ability to achieve this. For Matthew, the potential impact upon his learning was unknown, as the evidence for this would be most apparent within an educational setting and Matthew had yet to be successfully reintegrated back into school. What was



apparent was that Matthew was experiencing some difficulties conforming to the school rules as his previous attempt at returning to school had resulted in an exclusion due to his aggressive behaviour. This posed a potential risk factor for Matthew in helping him to return to school not only as it was unclear if he was able to regulate his behaviour but also because he had lost confidence in his ability to be able to return. There were however protective factors to support Matthew's return to school. Although he had been out of education for a long time this had enabled him to make further progress in his physical recovery following his ABI. Notably his speech and language had further improved and he was beginning to regain his sense of identity. This coupled with the fact that Matthew wanted to go back to school indicated that with some support his reintegration could be successful.

### ***Intervention at the individual level***

During Matthew's reintegration he had a number of one to one meetings with a trainee educational psychologist. During the sessions solution focused brief therapy (SFBT) was used to support Matthew in thinking about moving forwards. SFBT often starts with an initial interview (Gingerich & Wabeke, 2001) which encompasses core techniques (Lethem, 2002). For Matthew this was done over two sessions to build rapport and take into account any fatigue he may have been experiencing during his first week back. Following this the solution focused tools that were utilised changed each session but during the entirety of the intervention the following were used: scaling, the miracle question, questions about exceptions and what was supporting Matthew reach his goals (Gingerich & Peterson, 2012), looking for strengths and solutions (Kim & Franklin, 2009) and feedback letters between sessions (Laydon, Mackenzie, Jones, & Wilson-Stonestreet, 2008).

At the end of each session Matthew was asked if and when he would like to meet again. This is in line with literature on SFBT which aims to redistribute power between the practitioner and client (O'Connell, 2016). In total Matthew received 5 sessions of SFBT, with varying increments of time lapsing between sessions. Matthew initially seemed reliant on the sessions and increasing the gap between sessions over time aimed to reduce Matthew's dependency, whilst increasing his independence in school and his relationships with other adults. Between sessions Matthew was sent letters to summarise the discussions with an emphasis on achievements.

### **Working within microsystems to support Matthew's return to school**

For Bronfenbrenner (1979) the microsystems are the setting where the child can experience face to face interactions with others, such as the school and the family. For children and young people who have an ABI it is essential for parents, school staff, mental health professionals, and rehabilitation professionals to work collaboratively and proactively together to ensure vigilant screening, ongoing monitoring, and early intervention to reduce the negative effects of brain injury (Lindsay et al., 2015). The effects of ABI are often complex, affecting several areas of functioning and interventions need to address the multifaceted needs of children and young people as they return to school (Lindsay and Edwards, 2013).

Doherty and McClusker (2005) argue that children who sustain a head injury should follow a care pathway which includes identification and tracking during the first two years after hospital discharge. Some hospitals have specialist teachers who work with the rehabilitation team to offer an individual curriculum to the child for a few hours per day and other hospitals have schools attached to them where teaching is delivered (BPS, 2004). However, some children will return home directly from hospital and later return to school. In these cases, it is unlikely that schools will be educated about the needs of a child with ABI (Ball and Howe, 2013). Research indicates the importance of communication between hospital schools and mainstream schools, with discharge reports containing key recommendations being named as a helpful tool to communicate the needs of the child with an ABI (Ball and Howe, 2013). Providing more education and knowledge about ABI to school staff and peers can help increase support in school and reduce isolation and bullying (Lindsay and Edwards, 2013). Research suggests that teacher knowledge of the effects of an ABI is limited (Linden, Braiden, & Miller, 2013; Howe and Ball, 2017) and there is a lack of training available for school staff (Hartman, Duncanson, Farahat, & Lindsay, 2015).

### ***Intervention within the microsystem***

Support for Mathew's reintegration into school was provided in two areas of the microsystem, home and school. During the process of reintegration Matthew's father was contacted regularly. This allowed information to be shared about what was happening both at home and at school.

In the school environment the Special Educational Needs Co-ordinator (SENCo) was supported to develop a reintegration and support plan for Matthew, as he returned to school.

One of the most important risk factors for Matthew was his previous failed attempt to return to school and his subsequent exclusion. As a result of this school staff seemed apprehensive about receiving Matthew back into school. It was therefore important to begin building some protective factors for Matthew within the microsystem of the system. This was achieved partly through the reintegration plan which began with Matthew spending all of his lessons in the student support centre with a member of staff he had a good relationship with in the past. This separated him from the larger student population and some of the triggers to his anger.

As teacher knowledge of brain injury is limited (Linden et al., 2013; Howe and Ball, 2017) an information sheet about ABI and how to support the difficulties associated with it was created and distributed to staff. It was agreed that in addition to this staff needed to understand Matthew's personal experience of having an ABI and Matthew created a PowerPoint presentation to help staff understand how his ABI affected him. The SENCo put together a small team of support staff who would support Matthew during his reintegration, including herself and three others who she felt would be able to build a positive relationship with Matthew. Having slowly reintegrated Matthew into school during the end of Year 10 and beginning of Year 11, Matthew began to be reintegrated into some of his mainstream lessons at a pace set by him, with one-to-one support and the flexibility of returning to the student support centre if he felt he needed to.

One of the crucial parts of Matthew's reintegration was to work with the microsystems of the home and family to try and create improved relationships between Matthew's parents and the school staff. Following his exclusion, communication between home and school had broken down with his parents believing that the school staff did not want to support Matthew in returning to school. To achieve this the trainee educational psychologist acted as a facilitator to repair this relationship, encouraging the school to contact the parent to speak to them about Matthew's reintegration and arranging a meeting to discuss this. As contact and communication grew between home and school the role of the trainee educational psychologist reduced. This relationship increased the protective factors to support Matthew's return to school as when he was struggling in school or at home, contact was made and an agreement made on how to support Matthew in both microsystems. .

### **Consideration of the exosystem and macrosystem**

Although this work did not take place at the levels of the exosystem and macrosystem both played a part in providing an additional level of protection for Matthew. At the level of the exosystem the initial request for support from an educational psychologist came from the local authority as a result of the issuing of an Education, Health and Care Plan (EHCP) for Matthew. The work with Matthew arose due to his long absence from school and a request from the local authority to become involved and to let them know if any additional resources were needed. Speaking to the SENCo during the latter stage of the reintegration it became apparent that the EHCP and the funding attached to it was a supporting factor in putting Matthew's reintegration and support plan in place. At the level of the macrosystem Matthew's reintegration into school was supported by the fact that he has received a statutory assessment of his special educational needs under SEND Code of Practice (2015).

At the time of the statutory assessment of Matthew's special educational needs he had been discharged from hospital for nearly two years. As is commonly the case with pupils who have experienced an ABI, once Matthew was discharged from hospital he returned to the care of his General Practitioner without a Care Pathway. While difficulties for children who have experienced an ABI can emerge later as their brain develops, specialist services would usually only become involved through a re-referral. Thus there was no Care Pathway in place for Matthew and any medical documentation relating to his ABI was historic.

## **Results**

### ***Reintegration and attendance***

Matthew was successfully reintegrated back into school and at the end of this intervention he had started to return to mainstream lessons although he admitted to finding this challenging. Although he wanted to attempt full days of school from 8.40a.m – 3.30p.m, school staff and Matthew soon noticed that he was beginning to struggle more from headaches and fatigue and starting to take time off from school. As a result of this it was agreed between home and school that Matthew be allowed to start a little later to give him more time to rest and to allow him to go home early if necessary. School staff supporting Matthew seemed to recognise that some of the difficulties were medical and difficult to support. Overtime it became apparent that the main barrier to his progress was his headaches which had a debilitating effect on his ability to engage in school. However, through educating the staff on Matthew's ABI school staff were able to recognise the impact of this on Matthew both emotionally and physically and were flexible and understanding in their support. Matthew

seemed to develop positive relationships with the support team around him and was able to talk to members of the team when he was struggling, meaning that they could monitor how he was doing.

### ***Solution focused brief therapy scaling***

During the sessions scales from 0-10 were used to discuss progression. As Matthew's previous exclusion was due to physical violence he felt that '0' represented "losing it" (losing control of his anger) and '10' represented "staying calm and in control". During the first scaling Matthew felt that previously the worst he had been was a '2' when he was at his most angry, being hurt by others and hurting himself. During the session he felt he was a '7' as he said he felt calm and enjoyed working with someone who did not judge him and had a sense of humour. He felt he would like to get to an '8' at which point he felt he would be laughing, calm and walking away from conflict. With regards to his confidence in achieving his goals he was at a '5' and unsure if he could progress but willing to meet again.

In the remaining sessions Matthew recognised days when he had struggled, such as on his first full day, however, during scaling he regularly reported to be a '7' and happy with where he was and with the pace of his return to school. He felt that he might be at an '8' once he was into the routine and attending school at the same time as everyone else (8.40 a.m). He had also experienced successes in repairing broken relationships with staff members following an incident, something he was keen to reflect on and which seemed to give him confidence in successfully remaining in school.

However, the days following Matthew's 8.40 a.m. starts, he started to reflect that he may have pushed himself too hard during the first half-term of the year and this had resulted in a slight deterioration of his health. His headaches increased and his attendance reduced resulting in Matthew feeling he had moved down the scale. With this experience he soon felt he had now found a balance of what he could manage and when rating how he felt about his ability to stay calm and in control he felt he had moved up the scale to an '8'. He said that he was now able to remove himself from situations where he anticipated triggers.

### ***Additional outcomes***

In addition to Matthew's attendance improving and his perception of feeling more in control of his emotions there were other qualitative outcomes that are worth noting. Matthew had

developed positive relationships with the staff who were supporting him and during the fourth session Matthew spoke fondly about school staff and his experiences with them. He recalled positive comments from his English teacher, which challenged the negativity he had thought staff held towards him prior to his return to school. Members of support staff were keen to tell me how well he was doing and what a joy he was to work with. Matthew informed me that for the first time his father was proud of what he was achieving in school and that this motivated him to keep going. The change in Matthew himself was noticeable. Whereas previous sessions had a strong narrative of fights and anger, the fourth session contained only a positive narrative with Matthew keen to share his successes, seemingly more relaxed, smiling and laughing throughout the session, keen to continue his success. This felt like a turning point for Matthew.

## **Discussion**

### ***Facilitators to reintegration into school***

The Ecological Model of Development (Dunsmuir and Hardy, 2016) proved useful in supporting Matthew with his reintegration. In particular there seemed to be three main facilitators to Matthew's reintegration back into school across the ontological and microsystems; supporting and educating school staff during his reintegration within the microsystem, rebuilding the relationship between parents and school staff and the one-to-one SFBT work with Matthew at the individual level.

### ***Supporting and educating school staff***

At the level of the microsystem, it was important to recognise that Matthew's reintegration was not in isolation but within a larger system that would impact on him. As found in previous research (Ball and Howe, 2013) school staff had not been educated about the needs of a child with an ABI. Problems can be created or exacerbated through a lack of knowledge and understanding around the child's ABI and they may struggle to understand that the problem is the child's capacity, rather than willingness, to control disruptive behaviour (McClusker, 2005). This seemed to be the case for Matthew. It was evident that school staff were apprehensive about Matthew's return to school and his awareness of this made school seem unwelcoming and judgemental.

As found by Lindsay and Edwards (2013) one of the most important aspects of Matthew's reintegration was making sure that school staff were aware of his ABI and had information

and knowledge about how to support him during his time in school. General information sheets on ABI and a PowerPoint presentation created by Matthew to explain how his ABI had affected him seemed to achieve this. As outlined by Ewing-Cobbs et al. (2003) it was important that information sharing took place as Matthew moved from Year 9 to Year 10 so that his new teachers were fully informed about his ABI. Knowledge that does exist about a child's ABI tends to break down as the child moves across classes (Hawley et al., 2004) but using the information sheets and personal presentation created by Matthew it was quick and easy to disseminate information. Through interactions with school staff and Matthew it soon became clear that the narrative around Matthew had changed and that people were more understanding of Matthew presenting needs. Utilising the Ecological Model of Development (Dunsmuir and Hardy, 2016) highlighted the importance of information over time and recognising the chronosystem that Matthew was a part of; not only in terms of meeting needs that had evolved from his past but also in relation to the support and dissemination of information he would need in the future.

### ***One-to-one SFBT sessions***

As found in previous research, Matthew seemed to benefit from intervention that supported him in returning to his setting and coping with distressing emotions. Although some of his social and emotional difficulties seemed to be linked with his ABI there was also evidence to suggest that he had struggled with some emotional issues prior to his accident. This is not uncommon in children with ABI and can make it difficult for professionals to ascertain how far a young person's difficulties arise from the ABI or if they pre-date it (Schwartz et al., 2003). Matthew had identified that he felt a number of things were out of his control and was struggling to identify solutions to his problems, mainly reintegrating back into school and managing some of the strong emotions he was experiencing. The SFBT sessions seemed to be successful in supporting Matthew to identify his strengths and successes and by the fourth session discussion had become problem free and more optimistic. There also seemed to be a noticeable difference in Matthew and there were hardly, if any, reports of incidents. By the fifth session he felt more able to stay calm and in control of his emotions and felt able to walk away from situations. Although there is little research into using SFBT with children with ABI, previous research suggests SFBT can help students reduce the intensity of their negative feelings, externalising behavioural problems (Kim and Franklin, 2009; Franklin, Moore, & Hopson, 2008) and can be beneficial for aggressive and oppositional acting children (Conoley et al., 2003). This study seems to support these findings.

During one-to-one work with Matthew he expressed that he had negative experiences of working with professionals who had met him for a short amount of time, for a certain number of sessions and then would leave without having changed anything. This reinforced the importance of work within the microsystem and ensuring that it was the school staff who would be the main support rather than Matthew becoming reliant on sessions that would end. SFBT allowed flexibility in the time between the sessions, gave Matthew some control over when meetings would take place and allowed longer gaps so that support could slowly be withdrawn.

### **Barriers to reintegration into school**

As has been identified in previous research it is essential for school staff, mental health professionals, and rehabilitation professionals to work collaboratively and proactively together to ensure vigilant screening, ongoing monitoring, and early intervention (Lindsay et al., 2015). However, as professionals changed and time passed since Matthew's accident collaborative working and ongoing monitoring seemed to cease, resulting in Matthew being out of the school system for almost two years. There was little information available to indicate previous support or collaborative working and no paperwork from medical professionals to indicate the results of any neuropsychological assessments that were completed. Ball and Howe (2013) suggest that there seems to be a lack of effective communication between professionals, particularly once the child is discharged from hospital and the file information seemed to support this. Previous research indicates it is often the parent rather than the hospital that passes on information (Hawley et al., 2004), however, Matthew's father had not could not recall receiving any medical reports and had no additional information to share.

One of the main barriers to Matthew's reintegration was some of the medical implications of his ABI. Severe ABI is more likely to be associated with health problems such as tiredness, headaches (Hawley et al., 2004; BPS, 2004) and although Matthew had the determination, motivation and support to return to school he was struggling with headaches and fatigue, which impacted on his mood and ability to focus when in school. Although the school are being flexible in their support, Matthew's attendance started to dip as his fatigue and headaches got worse. Medical professionals are not able to help Matthew with this and it was difficult to accept that this support was limited, knowing that one of the main barriers to him



accessing education was a health issue. Despite these difficulties Matthew did continue to attend school and to build positive relationships over the following year while one of the authors was working as the school's educational psychologist.

### **Limitations**

The findings presented need be considered alongside the limitations of this study. As this is a study of one individual's reintegration back into school it is representative of an individual experience within the context of one school, their life experiences and the impact of their ABI. Therefore the reintegration discussed will be unique for that individual. This impacts on the generalisability of these results and the approach that was used during reintegration.

It seems likely that the combination of supporting school staff and Matthew resulted in a more successful reintegration, however, this is not certain. It is difficult to establish the impact of the SFBT sessions as a separate entity and whether it was SFBT as an approach that was supportive or whether it was just having one-to-one time to talk. In addition to this it is impossible to replicate one-to-one therapeutic sessions due to the human factors involved. In particular the interactions and relationship between the psychologist and the student will inevitable change which may act as a facilitative factor or as a barrier to progression.

Barriers to successful reintegration following an ABI remain, including effective information sharing and collaborative working between professionals. In addition to this children with severe ABI may have health difficulties such as headaches and fatigue which can impact on their ability to reintegrate fully back into school. Without collaborative working it is difficult to support such health difficulties.

### **Recommendations**

Although the findings of a single case study need to be treated with caution, EPs who are working with children and young people with an ABI who are reintegrating back into school may want to consider the following:

- Collaborative working with other health and education professionals involved
- Information sharing between health and education professionals
- Clear and up-to-date information in the EP child file through liaison with school, parents and other professionals

- Monitoring the individual with an ABI throughout their education and disseminating information to new school staff and professionals working with that individual
- School staff to be informed and supported in gaining knowledge about ABI
- Personalised information about the individual's ABI, the impact it has had on them and how they can be supported – keeping the young person at the centre of this information sharing
- Opportunities for one-to-one therapeutic work as the child returns to school to support their social and emotional wellbeing
- A clear formulation of the child's needs and strengths including ABI as a part of it rather than as the focus of it, taking into account factors both pre and post ABI
- Supporting the child to have a say in the pace of the reintegration and checking in with their wellbeing as the amount of time in school increases
- Providing opportunities for staff to learn more about ABI through training opportunities

## **Conclusion**

This research aimed to combine a therapeutic intervention within an eco-systemic approach in order to support Matthew's return to school following an ABI. The outcomes suggest that there were three key facilitative factors during the reintegrating of a child with an ABI back into school. These were supporting and educating school staff during the individual's reintegration, one-to-one therapeutic work with the individual and the psychological formulation of the individual's needs and strengths to support a personalised approach to their reintegration. This provides some preliminary support for the use of an eco-systemic model as outlined in Dunsmuir and Hardy (2016) when EPs are undertaking therapeutic work in similar cases. However as this work is based on a single case study the findings need to be treated with caution. There is a requirement for further research to provide a more robust evidence base in order to determine the role of therapeutic approaches within an eco-systemic approach.

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