I joined Doncaster University Centre in 2013 to undertake a foundation degree in Early Childhood Development and Learning in Practice. I then went on to complete a BA (Hons) in Early Childhood Studies. Throughout my studies I have always found the development of children’s social and emotional development fascinating. I developed a keen interest in attachment theories and how adverse experiences in early childhood impacts children’s social and emotional development. With this in mind, I decided to focus my research dissertation in this area.
Abstract

This research focussed on exploring how children are supported in relation to their social and emotional development in a primary school setting. The aims of this research were to highlight the different social and emotional interventions, identify if they are effective and to discover if early intervention takes place.

The case study approach was used as the methodology during the research, and mixed methods were used to gather the data. Semi-structured interviews were completed and non-participant observations took place. Goodman’s (1997) strengths and difficulties questionnaires were handed out to practitioners, parents and the children who took part in the research. These documents were then analysed to explore if social and emotional interventions in the setting enhanced children’s social and emotional development.

The key findings that have emerged from the research are that, the setting attempts to promote social and emotional development through 2 interventions, circle time and Thrive®. Thrive® is promoted effectively and children make improvements in relation to their social and emotional development and prosocial behaviour. Circle time is less effective, as it is not consistently implemented throughout the school. Practitioners lack of understanding regarding social and emotional development and their unwillingness to support children, places further pressure on the minority of practitioners who understand that these children need to be supported.
Introduction

In 1978 The Warnock Report transformed how children with a Special Educational Need (SEN) were included in mainstream school. Not only did the Warnock Report ensure settings promoted an inclusive approach to children with a SEN, it also outlined what constitutes as a SEN. Before this time children who had experienced social, emotional and behavioural difficulties (SEBD) were referred to as ‘maladjusted’ and offered little support to ensure they were included in mainstream school (Her Majesty Stationary Office, 1978).

Nearly 40 years on and advances in neuroscience has helped educators become more aware of the impact that SEBD can have on children’s wellbeing, attainment in school and future happiness as adults. In an attempt to support children’s social and emotional development (SED) and those experiencing SEBD, many settings now offer support to children in an attempt to address and eradicate barriers to learning and engagement within school. The implementation of the Social and Emotional Aspects of Learning (SEAL) (2005) saw many settings introduce social and emotional interventions to support all children within their care, with the focus on developing relationships and building confidence and self-esteem within children, to ultimately empower them to discuss their feelings and emotions (Department for Education and Skills, 2005).
Chapter One Literature Review

Historical Overview of Social and Emotional Difficulties and SEN

In 1927 the Child Guidance Council amalgamated with the National Association for Mental Health, with the intention to encourage provision and treatment for children displaying signs of SEBD, described then as maladjustment. However, because maladjustment was not recognised as a SEN no provision was made for children experiencing SEBD by authorities until 1944 following The Education Act. The 1944 Education Act sought to extend the provision that authorities would be obliged to make for children with SEN. It was in this act that maladjustment was first accepted as a category of disability requiring special education (HMSO, 1978). By 1955 provision for children with SEN was slowly expanding with early identification becoming increasingly prevalent. The importance of preventing and supporting children experiencing SEBD, rather than curing the affects made by them was becoming widely recognised amongst child care professionals (ibid).

The Warnock Report 1978 brought about changes to how children with SEN were included in mainstream school. The report highlighted that disabilities take on a variety of forms which differ in severity, therefore supporting the recognition of the complexities in regards to SEBD. Furthermore, The Warnock Report 1978 proposed that children with SEBD should be regarded as having a SEN. Alternatively, critics contended that the report did not recognise the under lying social factors that influenced educational experiences for children. Many professionals believed that the extended definition of SEN for maladjustment included a large number of low-
achieving children from disadvantaged background and proposed that their needs were not at all special but completely typical (HMSO, 1978; Goacher et al., 1988).

The Education Act 1981 was heavily influenced by the Warnock Report 1978. Children who displayed SEBD that were serious enough to affect learning experiences would now constitute as having a SEN. However, the 1988 Education Reform Act threatened the support that children with SEBD would receive. Schools would now be wholly responsible for raising standards and academic performance of pupils, therefore having less tolerance to children who needed more attention, particular those who displayed SEBD (HMSO, 1981; HMSO, 1988; Howe, 2005). More recently, educational settings have begun to realise the impact that SEBD can have on children’s holistic development. The Education Act 1993 placed great emphasis on supporting children’s SED, insisting that emotional development must be a central concern for mainstream education. It was also highlighted that children who cause schools the greatest concern are those with SEBD (HSMO, 1993).

**Attachment Theory and Social and Emotional Development**

The underpinning of SED takes place before birth and in the first three years of life. Connections in a baby’s brain form at the rate of 1 million per second. These connections grow from having around 10 million at birth to 200 trillion by the age of three years old. The result from such rapid acceleration leads to an 80% growth of a baby’s brain (Field, 2010; Allen, 2011; Leadsom et al., 2015). The success of this growth depends on the amount of positive experiences that the baby has with caregivers (Gerhardt, 2004). The first 18 months in a baby’s life creates a sensitive window of opportunity to promote SE learning before emotional responses become set (Gerhardt, 2004; Allen, 2011; Leadsom et al., 2015).
According to Astington and Edward (2010) the most significant development in early childhood, in regards to social cognition is the development of theory of mind. Theory of mind is central to children’s social understanding and enables them to get along with others and see things from other people’s perspectives. Children use theory of mind to express how they feel, explain their behaviour and consider other people’s feelings, thoughts and wishes. Children who have a better developed theory of mind are more socially aware, can read others body language and resolve conflict successfully (ibid).

Babies are receptive to emotions from birth and are programmed to be socially cooperative (Bowlby, 1988). Children are born with the instinct to socially and emotionally engage with people around them, in particular their mothers (Bowlby, 1988; Allen, 2011; Mathers et al., 2014). They take an active part in shaping intimate interactions with care givers by smiling, gurgling, imitating facial expressions and crying (Gerhardt, 2004; Dowling, 2014; Mathers et al., 2014).
However, Erikson (1968) and Freud (2006) believe that emotions are dependent on social awareness and argue that babies lack the ability to engage socially, therefore are incapable of feeling and expressing true emotion. In spite of these differing opinions, there is a resounding acceptance amongst theorists and early years professionals that early experiences shape babies emotional responses throughout life.

Secure attachments with parents during the first 3 years of life influences a child’s emotional health and wellbeing and are fundamental to children’s holistic development (Bowlby, 1973; Allen, 2011; Dowling, 2014; Mathers et al., 2014). These secure attachments enable children to develop along a healthy pathway, therefore encouraging social, emotional and physical development (Bowlby, 1988; Allen, 2011). Research suggests that good parenting, a loving stable home and positive attachments are predictive factors of children’s school readiness and future life chances (Desforges and Abouchaar, 2003; Bunting and Galloway, 2012).

Children’s learning takes place within the close relationships with caregivers, where they form the foundations of development including, social awareness, self-regulation and a sense of self-worth (Mathers et al., 2014). Bronfenbrenner (1979) describes this as the microsystem where the child’s most direct interaction with others takes place. The people in a child’s microsystem include parents, peers and teachers. These individuals heavily influence a child’s holistic development and can effect development both positively and negatively, depending on the type of relationship the child develops with these individuals (ibid).

Bowlby (1988) believes that infants are born with an array of developmental pathways which are potentially open to them. He describes this as the model of
developmental pathway. When babies are born they each have their own pathway for personality development. Some are compatible with mental health and some are incompatible. The particular pathway that a child precedes is determined by the environment, especially by the way in which parents respond to and treat the child. These pathways are being determined by every interaction a new born baby has with people and the environment around them. Children who form loving attachments to their care givers who are responsive to their needs are able to develop along a healthy pathway. By contrast, children who have insecure attachments, and whose care givers are unresponsive and neglectful are likely to develop along a pathway which can be compatible with poor mental health, thus, making them vulnerable to adverse experiences in later life. These insecure attachments can have a detrimental effect on children’s emotional development, making it difficult for them to regulate their emotions and develop essential social skills. (Bowlby, 1988; Field, 2010; Allen, 2011; Chowdry and McBride, 2017).

Childhood offers a critical window of opportunity to develop strong, emotional foundations that will dominate future development (Goleman, 2005). It is suggested
that early intervention is key to improving children’s lives chances, especially for those who have experienced poor attachments and adverse experiences in early life (Field, 2010; Allen, 2011; Leadsom et al., 2015; Chowdry and McBride, 2017)

**Early Intervention**

The early years are one of the most crucial stages of development in regards to changes in babies’ brains. The type of relationship a baby has with primary caregivers are hard wired into the brain (Bowlby, 1973; Field, 2010; Allen, 2011). Bowlby (1973) describes this as the internal working model which develops through the attachments that children have with primary caregivers and influences how the child sees themselves. A child who has experienced loving, caring attachments will develop a positive internal working model and go on to forge healthy, trusting relationships in the future. However, a child who has experienced poor attachments with caregivers from a result of neglect, abuse or adverse events may develop a negative internal working model.


A child’s internal working model acts as a prototype for future relationships and expectations from relationships during early childhood tend to remain unchanged
throughout life (ibid). Adverse events that children experience in early childhood can lead to structural changes in the brain that can affect children’s life chances (Field, 2010; Allen, 2011; Leadsom et al., 2015). Allen (2011) suggests that the first three years creates the foundations of emotional learning, where children learn how to express, understand and respond to others feelings. By the time a child has reached three years old the brain has grown to two thirds of its full size and has developed in complexity more than it will ever again, therefore the early years holds significant potential for learning and development (Goleman, 2005; Mathers et al., 2014). Many parents support children’s SED through this period by forging loving, caring relationships. However, not all children experience such positive relationships which can result in SE skills being absent in many children lives. Weak emotional foundations in early life can have detrimental effects on brain development, even if a healthy environment is later restored. However, this does not mean that later brain develop cannot occur, it just becomes much more difficult to restore emotional capabilities (Allen, 2011; Darling-Churchill and Lippan, 2016; Shulman, 2016). Freeman (2016) describes the brain as ‘plastic’ which can develop and change within reason, but also recognises the challenges of restoring emotional capabilities becomes much more difficult as a child grows older. To summarise early emotional problems do not have to lead to poorer outcomes as adults if they are addressed appropriately (Chowdry and McBride, 2017).

It is estimated that England and Wales spend nearly £17 billion a year on late intervention to address adverse experiences that affect children. Local authorities including schools, bear the largest share of £6.5 billion a year in providing children and families with support (Chowdry and Fitzsimons, 2016). Early intervention can
significantly reduce the probability of poor outcomes for children in later life. Early identification of BESD prevents difficulties from becoming ingrained in the lives of children meaning they are far less likely to need expensive, statutory intervention in later life (ibid). Through early intervention and building essential SE skills in children; the cycle of disruptive behaviour and unmanageable children in schools can be reduced (ibid).

**Social and Emotional Support in the School Setting**

Schools offer the ideal environment where children can be taught emotional literacy and test out SE skills in a safe and secure way (Goleman, 2005). Mathers et al. (2014) describes a key dimension of quality pedagogy for children include developing stable relationships and interactions with caring, responsive adults. While a setting can never replace the type of SE interactions children experience within the family unit, practitioners can work closely with caregivers to share the task of supporting children to understand their emotions and feelings. Practitioners are able to take advantage of the receptive nature of children to support them to achieve emotional health and wellbeing and also to help children to learn how to manage their behaviour and make appropriate choices (DfE, 2014; Dowling, 2014; Shulman, 2016).

Research suggests that 1 in 10 children aged 5 -16 years suffer from a diagnosed mental health disorder. This equates to 3 children in every class in England (Young Minds, 2016). These statistics have led to strong concerns about children’s SED in England. Dowling (2014) argues that the link between mental health disorders in children is related to the rise in academic pressures that are thrust upon them.
Goleman (2005) agrees and believes that schools are fixated on academic abilities and as a result are ignoring children’s emotional wellbeing. However, teachers are also overburdened with the pressure of ensuring that children make academic progress. The pressure on raising standards has forced them into practices they intuitively know are counter-productive for children (ibid). The pressure on teachers to ensure children progress in topics such as maths and English has resulted in the teaching of SE skills being forgotten (Dowling, 2014).

However, the lack of training for teachers to prepare them to relate to children experiencing SEBD has resulted in them avoiding teaching emotional intelligence (Goleman, 2005). It may also be suggested that education is not about emotional wellbeing and it is a teacher’s role to promote learning opportunities not take on the role of psychologists (Cefai et al., 2013). However, research suggests that the quality of pedagogical practices, especially when supporting children’s emotional development through fostering positive relationships facilitates children’s holistic development (Mathers et al., 2014). Children themselves can refuse to engage in SE interventions feeling that they are too intrusive or that they are being singled out from their peers (Goleman, 2005). It may also be argued that vulnerable children are
labelled and stigmatised through the implementation of intervention groups that target specific groups of children (Cefai et al., 2013).

Children are thrust into social situations as soon as they enter a classroom. An anxious, awkward child may misread their peers and teachers and fail to grasp the nonverbal rules of interaction. This puts them at a risk of social exclusion, therefore resulting in anxiety and panic which can disrupt learning and impact on academic performance (Goleman, 2005), especially for those children who have a less developed theory of mind. Children learn in collaboration with their teachers and in the company of their peers, which is why teaching and learning in schools have strong SE components. Emotions can impact on children’s academic engagement, work ethic and overall school success (Durlak et al., 2011). Stanley (2015) believes that schools need to take a more active role in in the promotion of mental health and wellbeing in children. A broader approach to education to include SE learning would help to tackle the variety of life challengers that children face. Howe (2005) believes that there needs to be more recognition that many children are born into circumstances which often deny them positive early experiences. In this instance schools can make a great difference in improving the life chances of these children by supporting their SED through intervention programmes.

**Interventions**

Schools have become the main focus of efforts to reverse the trend in poor mental health and as a result preventive SE learning interventions have become universally
popular (Humphrey et al., 2013). In 2005 The Social and Emotional Aspects of Learning (SEAL) was launched by New Labour in the primary school sector. The intention of the SEAL programme was for schools to foster SEAL learning outcomes through an explicit curriculum, then to reinforce them throughout all curricular areas and the school (DfES, 2005). SEAL is described as an inclusive approach to promote SE skills, to enhance effective learning, promote positive behaviour and emotional wellbeing of all children in schools. Although SEAL has been officially discontinued 90% of primary schools still foster the approach (Humphrey et al., 2010). However, research suggests that SEAL programme was overrated and failed to make a measurable impact on children’s behaviour and SED. Studies have suggested that schools failed to implement the programme with fidelity, did not prepare for the workload challengers and failed to support practitioners by providing them with the knowledge and understanding of social and emotional interventions and how they support children’s wellbeing. The perception that SEAL programmes would lead to better academic results, more effective learning and better behaviour led to high expectations amongst practitioners. When this could not be achieved it acted as a barrier to implement the programme successfully, with many practitioners withdrawing their efforts from the programme (ibid).

Circle time (CT) is one of the most widely used interventions aimed at promoting children’s SED (Cefai et al., 2013). CT supports practitioners to deliver well structured, purposeful lessons that help to deliver the curriculum for SED and provides a safe base in which children can express emotions, problem solve and practice listen skills whilst supported by an adult (Mosley, 2015). Goleman (2005) suggests that CT opens the door for children to be able to express their feelings in a
safe and controlled environment. The issues children discuss are often those that have been troubling them which they have kept themselves.

However, Cefai et al., (2013) argues that there has been a lack of studies measuring the outcomes of CT and proposes that it is often used as a tool for behaviour control. In situations where children are asked to explain how they feel or tell everyone about something they have done, their replies are often limited and inhibited as opposed to when they choose to interact spontaneously (Fisher, 2016).

When it comes to school based interventions, SE programmes are not a one size fits all. Humphrey et al. (2010) proposes that a balance is needed to achieve support for all children, through targeted and indicated interventions. However research findings indicate that teachers fail to implement SE programmes as intended by programme designers (Ringwalt and Ennet, 2003). An exploration into the social and emotional intervention programmes in a primary school setting will help to identify if children benefit from programmes designed to promote emotional wellbeing and if settings do intervene early enough to prevent adverse experiences impacting in later life.
Chapter Three Research Findings and Discussion

Three key themes have emerged from the research as a result of using grounded theory. The three key themes identified are:

- Delivery of interventions
- Measuring the impact
- Attachments

**Delivery of Intervention: Lack of Understanding**

Goleman (2005) suggests that the lack of training results in teachers feeling unprepared and inexperienced in supporting children’s SED. Similarly, Humphrey *et al.* (2010) claims that SE interventions fail mainly due to the lack of understanding, knowledge and skill base that practitioners possess. The interview responses also suggest that there is a lack of understanding amongst practitioners, regarding the importance of SED. Question 16 asked if the participants had experienced any challengers in delivering SE interventions in the setting. The Inclusion Manager discusses her challenges:

> I find the most challenging factor is other staff members not understanding what it’s all about… What I find the most challenging thing is not having the support of your colleagues…

(Appendix 13, U28)

The Thrive® practitioner states similar concerns:
There’s probably the odd one of them that’s got a bit more understanding but I don’t feel that, well it’s not embedded throughout school and it’s not something that people think we should be doing… (Appendix 15, U28)

The importance of training in SED is advocated by Mathers et al. (2014) who believes that the key to providing quality care and support to children is practitioner training and understanding. This confirms the Inclusion managers view that the lack of understanding of CT, Thrive® interventions and the importance of SED, may be related to the lack of training opportunities:

…There’s really not a lot of training I suppose. Thrive practitioners went on training which is all about social and emotional development but no one else, so I suppose they don’t know the importance of it. (Appendix 13, U16)

…But in teachers defence they’ve never had any training on circle time or even emotional wellbeing for that matter (Appendix 13, U22)

**Children’s Unwillingness to Engage during Intervention Sessions**

Goleman (2005) suggests that children often feel singled out from their peers when taking part in SE interventions. The responses given in the interviews correspond with Goleman’s (2005) theory. Question 3 asked if children engage in CT intervention. The TA stated:

…I feel that some children wouldn’t necessarily say that they are upset, angry or worried, cos they might feel embarrassed to say they feel like that.
Sometimes they might not wanna have other children asking them what’s wrong or to know why they’re upset … (Appendix 14, U20)

This view is also reiterated by the Thrive® practitioner:

…A lot of children don’t want to join in. I mean they’re in front of their friends and it must be hard to really say how you’re feeling and then again you might not even want too… (Appendix 15, U36)

The Inclusion manager had a firmer view on why children might not engage in CT intervention:

…it’s very intimidating for some children that don’t like to speak out in front of anybody, let alone to discuss their emotions…. I’m not a big fan of circle time at all (Appendix 13, U20)

The view that many children are unwilling to join in during intervention groups was also apparent during the CT observation of year 2, with 45% of children refusing to take part, compared to 100% of children taking part in Foundation 2. The field notes collected during the observation suggest that the practitioners in Foundation 2 were more responsive to children’s feelings and emotions during the session. It may be suggested that through developing the key person approach in early years settings, has enabled practitioners in Foundation 2 to form special relationships with the
children in their care. Therefore, practitioners are able to build attachments with the children and attune to their needs (Bowlby, 1988; Elfer et al., 2003).

CT appeared to be less effective in the setting than the Thrive® intervention. Responses during the interviews regarding the Thrive® intervention were more positive. Question 4 asked if children engaged in Thrive® intervention, the Inclusion Manager stated:

*Definitely, they engage in Thrive. They like the one to one sessions...*

(Appendix 13, U30)

The TA went on to suggest that she believes Thrive® has had an impact on children in the setting:

*I think some children who have been getting Thrive on a regular basis have, you can see it. You can see that they look forward to Thrive. A couple of children out of my class go to Thrive, and they’re behaviour and how they treat others has definitely improved...* (Appendix 14, U28)

The field notes collected during the observations also show that children engaged well during Thrive® intervention. During the first session that was observed (see appendix 18) the Thrive® practitioner (Mrs Neil) works with the child (Mark) to explore feelings and how these are linked to sensations in the body. Mark remains engaged throughout the activity, as he and Mrs Neil explore how to recognise different feelings and how to act on them appropriately. Mrs Neil supports Mark to overcome difficulties that he faces whilst playing on the playground, and also supports him to take in to consideration other children’s feelings. Field notes
collected during the second session of the Thrive® intervention also show that the child (Harry) engages (see appendix 19). Harry explains how he has missed Mrs Neil during the school holidays and he is happy that he is back so he can continue going to Thrive®. The session is focused around making Harry feel special and helping him to gain an understanding of how his actions can make other people feel. Astington and Edward (2010) suggest that the development of theory of mind is essential for children's SE development. During the Thrive® intervention Mrs Neil attempts to develop the children’s theory of mind, encouraging them to express their feelings, think about their behaviour and take into consideration the feelings of others. It might be suggested that developing children’s theory of mind through Thrive® intervention, explains why children’s behaviour and how they treat others is improving throughout the school.

All children who took part in the Thrive® intervention began with high scores of difficulty. Figure 1 illustrates the improvements children made during the 12 week Thrive® intervention. The referrer completed the SDQ 3 times over a 12 week period. The results show the total score of difficulties at week 1, week 8 then again at week 12. All children with the exception of Child J showed improvements in behaviour and SE wellbeing. Child J completed the intervention showing no improvements.

Figure 1: Strengths and Difficulties Questionnaire Referrer Results
The referrer also completed a prosocial score for the children who took part in Thrive® intervention. Again this was completed at week 1, week 8 then again at week 12 of the intervention. All children made improvements in regards to their prosocial behaviour, with the exception of Child J whose prosocial behaviour made a negative change.
**Lack of Early Intervention**

This research has highlighted that early intervention through SE intervention does not take place. During the interviews all participants expressed awareness regarding the importance of early intervention, but highlighted that the setting does not promote it. Question 22 asked if the setting promoted early intervention. The Thrive® Practitioner stated:

…No, definitely not. It should be started as young as possible …. If we caught them really young and really focused on early intervention I think it would work.  

(Appendix 15, U32)
This correlates with Shulman’s (2016) suggestion, that if supported effectively during the early years, children are able to develop regulatory strategies, which help them to align their behaviour with social expectations.

The TA also stated that she has never been aware of early intervention in the setting:

…I do know that the little ones aren’t included in the interventions. I’ve never known of a younger child getting that type of support….  (Appendix 14, U34)

However, the Inclusion Manager expresses the difficulties that she faces in trying to promote early intervention:

…In an ideal world it’d be good to target the younger children as they’re coming in, before any issues develop…. Like I say at the minute we’ve been fighting fire with petrol, trying to get behaviour improved before we’re able to do that, but that’s our long term goal.  (Appendix 13, U26)

The Inclusion manager goes on to state that she targets children for SE interventions who are in year groups between year 2 and year 6, as this is where problems with behaviour are more prevalent. Lower key stage 1, therefore are not targeted because issues with behaviour are not a concern. Referring back to the observation of CT in Foundation 2 (see appendix 17) indicates that CT intervention was carried out successfully. Practitioners helped children to express and understand their feelings. Practitioners were consistent in their approach of dealing with children’s feelings and displayed a calm and caring nature, listening to each individual child.
This together with the positive attachments that are formed with children in Foundation 2 may suggest why behaviour is not an issue in the lower key stage of the school. However, it appears as when children move up through the key stage, issues with behaviour increase and this is when SE interventions are then used. It might be argued that practitioners who are responsive to children’s feelings and give them the opportunity to discuss their feelings through a well-planned and appropriate intervention results in SE issues being discussed and resolved. It also appears that the setting relies on late intervention to tackle issues with behaviour as opposed to early intervention, which can significantly reduce SE issues from being ingrained in children’s lives (Field, 2010; Allen, 2011; Chowdry and Fitzsimons, 2016). As Allen (2011) suggests, early intervention for SED can help to reduce the risk of unmanageable and disruptive children in schools.

**Measuring the Impact**

**Lack of Tracking Data**

Although it is evident that the setting tracks the SE intervention of Thrive®, using the programs online tool, it remains unclear to practitioners and the school what improvements children are making. The Inclusion Manager explains that the only intervention that the setting tracks is Thrive®, although this appears to be used for only Thrive® Practitioners purposes, to plan future activities for when children come to the sessions. Question 21 asked if the setting shares the results. The Inclusion Manager goes on to explain:
I think that cos Thrive is quite complex the measuring isn't very clear. Progress isn’t really measured as a whole school

(Appendix 13, U40)

The Thrive® practitioner emphasises on this point:

… As a Thrive practitioner I measure the impact, as a school no... I need to do it to see what stage the child is working at so I can plan different activities. The improvements they make aren’t shared or used for anything other than my activities. So no one knows how the children are doing or if Thrive is really working, apart from me.

(Appendix 15, U42)

During the interview the Inclusion Manger raised concerns that Thrive® may be pulled from the school altogether:

…It’s a long term intervention and I think again that’s something what we might struggle with, it not being an overnight thing

(Appendix 13, U32)

… It’s guna take so much time to make a difference and improve children’s social and emotional development, it might be seen as not making a difference and pulled from the school altogether

(Appendix 13, U34)

It might be suggested that fears regarding the intervention being pulled from the school has derived from the lack of monitoring and measuring children’s progress and the impact that Thrive® intervention has on the school. If the intervention is not
tracked and progress is not shared, then in may appear that this type of SE intervention is having no impact on children’s SED and behaviour. This is in fact what Humphrey et al. (2010) states that led to the downfall of the SEAL in schools. Practitioners failed it implement interventions and did not prepare for the workload challengers. When they believed that SE interventions made no impact on children’s attainment and behaviour, practitioners withdrew their efforts from the programme. However, for the purpose of this research children’s SED was monitored over a 12 week period and it is evident that the majority of children made improvements in relation to their SED.

Figure 3 illustrates the overall impact of the Thrive® intervention. Once the data from the SDQs had been analysed, it highlighted the overall impact of the Thrive® intervention, and shows that a positive change occurred for 75% of children and no change for 25% of the children.

**Figure 3: Impact of Thrive Intervention**

![Pie chart showing 75% positive change and 25% no change](chart.png)
Attachments

Whose Job Is It To Carry Out Social and Emotional Intervention?

Through building positive attachments with children in the setting, practitioners can act as a ‘go to’ person when a child feels that they are in need of support (Elfer, et al., 2003; Dowling, 2014). This has also been identified in the responses from the TA and Thrive® Practitioner during the interviews. Question 11 asked whose job is it to form attachments with the children. The Thrive® practitioner explains she feels responsible for being the child’s ‘go to’ person:

...So, I'm here to build relationships with these children and try to develop attachments so they can move on and try to develop relationships with others in school... (Appendix 15, U6)

...I'm like the person that's there for these children, to help and support when I can. (Appendix 15, U16)

The TA also explains that if a child discloses a problem during CT it is her role to ensure the child is supported:

...Then that's like my role, so the teacher will turn round and say do you want to talk to me.... (Appendix 14, U6)

However, all participants expressed concerns regarding the limitations children face when they require SE support and the confusion amongst practitioners of who should be available to support these children. The Inclusion Manager explains:
…Some staff members don’t feel that that’s their job. Many come to school to learn and teach children so emotions are thought of another side to their job I think.... (Appendix 13, U16)

The TA explains the dangers of children not knowing who they can go to for support:

…They’re thinking (the children) that it won’t be took serious anyway, so what’s the point. It’s probably the children not trusting who to go to.... (Appendix 14, U22)

The Thrive® Practitioner shares similar concerns:

…I kind of get the feeling cos I’m now the Thrive practitioner that’s my job and the teaching and learning is the teachers’ job, the two just don’t mix and they should. Could you imagine how many children we could support if everyone got involved? (Appendix 15, U20)

Through secure attachments children are able to develop empathy, theory of mind and positive relationships with others (Bowlby, 1988; Astington and Edward, 2010; Allen, 2011; Mathers et al., 2014; Dowling, 2014). However, it might be suggested that some practitioners do not feel it is part of their job role to support children’s SED. The assumption that the setting focuses on academic results rather than supporting children’s SE wellbeing is also expressed during the interviews.
The Thrive practitioner states:

...It's too much on maths and English and achieving high scores...

(Appendix 15, U20)

The Inclusion Manager agrees:

...There's more focus on academic results

(Appendix 13, U12)

The perception that some practitioners do not feel it is their job to support SED, coupled with the view that the setting places more emphasis on academic results coincides with Goleman’s (2005) theory that settings place too much emphasis on academic results which means that children’s SE wellbeing is being ignored. Additionally, it might be argued that teachers simply do not feel comfortable to discuss feelings and emotions and it is their job to educate children in subject areas such as maths and English not emotional literacy (Cefai et al., 2013).

**Chapter 4 Conclusion**

This research has highlighted that although the setting attempts to support children’s SED through intervention programmes, they are not as effective as they should be. The successful implementation of CT varies from class to class, whilst some practitioners ensure CT takes place on a daily basis and that it is planned well, others fail to implement it at all. Thrive® intervention has a positive impact on SED for the majority of children that attend. However, interviews with the TA, Inclusion Manager and Thrive® practitioner found that they feel unsupported by the majority of
their colleagues when attempting to support children’s SED. Practitioners lack of understanding has led to confusion regarding who should be supporting the emotional needs of children in the setting. Thrive® has failed to be implemented as a whole school approach which may suggest the lack of understanding and willingness of practitioner’s engagement with the Thrive® ethos.

The findings from the research highlights that when structured, individualised intervention programmes are implemented appropriately, a child’s SED, behaviour and prosocial behaviour improve. Practitioners who attune to children and validate their feelings, presents with the opportunity for them to open up about their own feelings and worries, leading to discussion and the opportunity of difficulties being resolved. This research therefore is able to inform other schools, that when children’s SE wellbeing is supported, through positive practitioner and child relationships and the implementation of intervention programmes, children’s SED, behaviour and prosocial behaviour can be enhanced.
References


Freeman, J. (2016) Neglect In Early Years Can Cause Lasting Brain Damage. *Children & Young People Now*. 3 pp. 21


